Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ctober Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and n 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arunde Social Security Number ar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 242-14-5393 1 XM 2 🗆 F 89 6, 1923 NC or than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 No Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21037 8 Lee Air Park Dr. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWII Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ۵ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Completed **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Engineering Tech Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any Injury or other traumatic e once. Clara Walker Samuel A. Halsey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewater, MD 21037 Paul A. Halsey - Nephew 3493 Monarch Dr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 10-18-2012 Cheltenham, MD Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequent Exami ng physician and as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the at the detached for Pregnant at time of death 2 🗌 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မူ Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one 3 Kertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific ath (Item 23a) (Type 304 Name and address of person 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar 26

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

20 | 2 34503 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Nixon Physician/ King Month illit 2017 2:304M ctober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore venue If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min. Hours 73 Director 220-36-6379 1 M 2 F Oct 23, 1939 North Carolina er then "nature!", or items 23a or 28a-f show the Medical Evariner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 United States 2106 Walshire Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. **Black** 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Dept. of Social Elementary/Secondary (0-12) College (1-4 or 5+) Services Case Manager is marked other 1 and 2 should be filed w of Health and Mental Hygi item 27 is marked othe other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore Nixon Naomi Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda King /Daughter 2106 Walshire Avenue Baltimore, MD 21214 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
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eny injury or ott Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oct 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancu disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) Pregnant at time of death 1 Yes 2 No page 2 should be detached 9 D Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No After this certificate has 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 욛 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 \subsection Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number MSKG apathenio D0057465 10/25/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltoner MD 21209 5203 NSRAWPAKZEMD 2835 Smith 31. Date filed (Month, Day, Year) OCT 26 legistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret B. Knauer 4:05 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Franklin Square Hospita Roseda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland Director 215-16-7733 1 🗆 M 2 💢 F 90 October 08,1922 27 Is marked other then "netural", or items 23e or 28a-f show treumetic event, the Mocked Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Baltimore Maryland Parkville 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours efter death with 8810 Walther Blvd. Suite 1514 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 Tes 2XXNo Specify: Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h end Mental Hyglen 7 Is marked other th 12 Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be a sent of Heelth end Merarit if item 27 is a reference or injury or other tr ည William H. Burton Margaret Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 8810 Walther Blvd. Suite 1514 Parkville, Maryland Richard Knauer (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e
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Importent: If ite
eny Injury or ott October 24, 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkville, Maryland Parkwood Cemetery 2012 21. Signature of Fun and Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremetion Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani Kespiratory disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respirato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physicien: The law requires that the deeth certificate be executed neumonia physician end s the burlel-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 $^<$ es ettending if for use es IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No After this certificate I funeral director, pag 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mannes of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 5 0000 person who completed cause of death (Item 23a) (Type, Print)

State Registrar

margare

Square Drive

9000 Franklin

yindem

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O Chaber 1. 40A-M 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Ranger N/A living Conk Baltimore Commun 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Days Hours 219 36 6562 1 M 2 □ F Director 72 Maryland 06/06/1940 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other then "natural", or Items 23e or 28a-f show treumatic event, the Medical Externior marks - - ... 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 X Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A. 4150 Doris Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Viet Nam Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ≨ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas F. Kelley Sr. Emma Lord l and 2 should b f Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Donna Kelley / Wife 4150 Doris Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ₽ 1 Burial 2 X Cremation 3 Removal from State 10/30/2012 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway 233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pnysician/ Pulmman disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami attending physician and for use es the burial-transit or Attending Physician: The law requires that the deeth certificete be executed that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760<Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ed by the a 1 ☐ Yes ∠ L 9 ☐ Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> cate has been signe, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Hospitel or Attending Physician: The within 24 hours after death.

To the Funerel Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 057239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Policy Baltemore Ochbur 22, 2012

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 34506

State of Maryland / Department of Health and Mental Hygiene Marie Lillian Keller 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 4, 2012 1145 hrs **Medical Examiner** Marie Lillian Keller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale **Baltimore County** Franklin Square Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director Country)Maryland 2 X F 1 M 52 03-23-1960 216-66-3951 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location M 10a. State 10b. County 1 X Yes 2 No s 23a nr 28a-f show s notified at once. MD Baltimore Essex yes I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", ar items 23a nr 28a-f she ther traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21221 Vandermast Lane 2341 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No White 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Did Not Work N/A 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Keller Sr. Margaret Jankiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) at: If item 27 i 425 Virginia Avenue, Essex,MD,21221 Trista Keller/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Pages 1 Burial 2 X Cremation 3 Removal from State 8/9/2012 Beltsville,MD Chesapeake Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Maryland Cremation Services, PO Box 1413 Baltimore, MD, 21203 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED e attending physician for use as the burial P.O. Box 68760, es that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown chronic obstructive pulmonary disease Completed Division of Vital Records, has been si 2 should b 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed icate 1 director, page Yes 2 V No 1 Yes 2 No certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 V Yes 2 No 28a. Date of Injury (Month, Day,Year 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 V Natural 1 Yes 2 No Pending death. in by the Director: 2 __ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City hours after 3 Suicide Could not be or Town, State) To the Hospital r within 24 hours at To the Funeral I determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 7, 2012 Pernuli Muthall ma 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) edistrar's Signatur State

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 19.20129:00 Marilyn Sue AM Kelly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4440 Willard Avenue, #540 Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Hours (Month, Day, Year) 444-38-5427 Director 1 🗌 M 2 ី F 72 January 8, 1940 0klahoma Usual Residence of Deceder 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified Cleveland 0klahoma Oklahoma City 1 X Yes 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ō must be Funeral 73170 2100 Dansmere Avenue United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) er than Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Grocery 27 is marked other r traumatic event, tl Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oscar Eugene Stansbury Maude Jane Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4440 Willard Avenue, #540, Chevy Chase, Maryland 20815 Conni Lynn Allen /Daughter Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oklahoma City, October 29 cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Resthaven Memory Gardens 2012 0klahoma 4 Donation 5 Other (Specify) Signature of Fun a Service J Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue, Bethesda, Maryland 20815 Chase, Inc. angelette Brisis M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Day Year signed by the at d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No page 2 certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Spec Daughter' မ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 X Natural s after death. Accident Investigation the Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Medical 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the Fune completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouakhou, mo 06374 jour lync 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Jocelyne Kouatchou, MD 31. Date filed (Month, Day, Year) State OCT 26 2012 Registrar

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar	yland / Depa <i>Cer</i>	artment of ⊦ <i>tificate of E</i>		Mental Hygi Re	ene 9. No.2 0 1	2 34508
Ī	Physicia		1. Decedent's Name (First, Middle, Last ANTHONY MATH	,	HAJDA			2. Date of Death OCTOBER		3. Time of Death 3:30 AM
	Medic Examin		4a. Facility Name (if not institution, give	street and number)			Location of Death		4c. County of De	
	Funeral Director		5. Social Security Number 6. S		n yrs. last birthday) 95 _{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. E	Birthplace (State or Foreign Country)
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	e Maryla r 28a-f s notified	Director	MD BAI 10e. Street and Number	TIMORE		RO 10f. Zip Code	SEDALE	1.0	0	1 🗆 Yes 2 📉 No
	h with th ns 23a o nust be	Funeral I	812 ROSEDALE	AVENUE			2123	7	g. Citizen of What U . S	S.A.
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 1 □ Never Married 2 □ Married 3X Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	lf o	Vas Decedent of Hi FYes, specify Cuba ☐ Yes 2X No	n, Mexican, Puerto		Black, Wi	merican Indian, nite, etc. WHITE
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Maryland	ould be f nd Menta marked imatic ev	2	ANTAL L 19a. Informant's Name/Relationship (7)			a Address (Street	MARIE	B .	lity or Town State	NOVAK Zin Code)
e, Ma	and 2 sh Health ar em 27 is ther trau		LINDA WOLFF/DA 20a. Method of Disposition			ROSEDAL		JE ROSE	DALE, M	D 21237
Baltimore,	Page 1 tment of tant: If it jury or o		1 Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		GARDENS	OF FAIT	'H 10-2	24-12	BALTIMO	RE, MD
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	nysician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.						Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a c	onsequence of):	Artero	ozia g	- ۱۵۰ و د		
	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onibequanica oi);					
09	ate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a c	onsequence of):					
6876	certificate Iding phy Ise as the	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy	7			23d. Date of	delivery
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s, P.O	res that the signed by do be deta	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	ren in Part I.			to the cause of death? Probably 4 2 Unknown
cord	law requi nas been e 2 shoul	Completed						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
al Re	sician: The law is certificate has the lirector, page 2 s	Be Cor	25. Was case referred to medical examiner?			26. Pla	ace of Death (Che	perform 1 Yes 2		Yes 2 No
of Vit	g Physic er this ce neral dire	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury (Month, Day, Y	28b. Time of	28c. Injury	at	ome 5 XResiden 28d. Describe how		ecify)
Division of Vital Records, P.O.	Attendin ar death. ector Aft by the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injury	- At home, farm, stre		Yes 2 No			Rural Route Number,
2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical Ce		building, etc. (Sizinate Sician: To the best of my		occurred at the time	e, date and place	City or Town,		stated.
	o the Ho ithin 24 h o the Fur ompletely	Med	(Check 2 Medical Exam	iner: On the basis of exar se Practitioner: To the b	mination and/or invest	igation, in my opinic	n, death occurred he time, date and p	at the time, date and lace, and due to the	place, and due to th	ne cause(s) and manner stated. or as stated.
	<u>- 5 - 0</u>		s. Rcog	erap.	MD	00	PS372		101271	
			30. Name and address of person who come to the second of t	completed cause of deat	th (Item 23a) (Type, P	rint)	Ra, I	Belcair,	wo	21015
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature					

DHMH 17 Rev 06-2011

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Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month KLEIMAN 245 AM 2. Medical (OC) 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WEINBERG PARK ASSISTED LIVING BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 217-38-6663 1 X M 2 □ F Yrs. 71 03/25/1941 MD ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Directo MD N/A 1X Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5833 PARK HEIGHTS AVENUE 21215 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Ś 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) TELEMARKETER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည other traumatic NORMAN ge 1 and 2 should but of Health and Mer: If item 27 is mark KLEIMAN ELSIE SPITZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS FRIEDMAN/ATTORNEY 409 WASHINGTON AVENUE, #900, TOWSON, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If i
any injury or o 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 10/25/2012 WOODLAWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that cause shock, or hear failure. List only one cause on each lin ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Sudden Immediate Cause (Final disease or condition resulting in death) Physician/ in farction MYOCAPENIAL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Fibrilation 1 🗹 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted ည 1 Tes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 3037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUBBLET M. COOPER MP 6503 PAPLIC HEIGHTS AME WW 21215 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

ORIGINAL

			AMEND #25, PER	ase Type or Pr	int in BI	lack In	delible In	k. Ens	sure All C	opies	Are Le	gible		
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	Physicia	an/	Decedent's Name (First, Middle	e, Last)	<u> </u>				1 .	ate of Death	h	V	3. Time of	Death
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	Examir	ner	4a. Facility Name (if not institution WMHS-Frostburg		ehah C	enter	4b. City, Town, o		of Death			nty of Deat egany		
	Funeral		5. Social Security Number		ge (In yrs. last		If Under 1 Year Months Days	If Under		ate of Birth		9. Birt	thplace (State o	r Foreign
	Director		218-24-8705 Usual Residence of Decedent	XMZDF	86	Yrs.	Worth's Days	Hours		Month, Day, Ine 27	, 1926	j Ma	untry) ryland	
	land show dat	ţ	10a. State 10b. County		10c. City, To	Town or Loc	ation						10d. înside Ci	ty Limits
	e Mary r 28a-i notifie	Sired	MD Alleg	gany	Mot	unt S							1 🗆 Yes	2X No
	with the	Funeral Director	10e. Street and Number 15620 Mile Lai	no Mu			10f. Zip Code	-		11	0g. Citizen o		ountry?	
	leath v tems er mu	Fune	11. Marital Status	12. Was Decedent		13. V	2154 las Decedent of F Yes, specify Cub		igin? (Specify Y	es or No-		SA ace - Ame	rican Indian,	
36	after d I", or i		1 Never Married 2 X Mar	W Von Cite	No	1	Yes, specify Cub ☐ Yes 2 🗓 No			, etc.)		lack, White		
21215-0036	nours natura ical Ex	Completed by	3 Widowed 4 Divorced	Year or Dates,	' 50 - 5	2	ent's Usual Occur				16b. Kind of			
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121	Hygier Hygier Ither t	Be C	10 17. Father's Name (First, Middle, I	0			draftsm					Govt	<u> </u>	
land	be file lental I rked o iic eve	10	George W. Land	,				1	ier's Name <i>(Fir</i> si Lce V. (laiden Surnai	ne)		
Maryland	should and N is ma aumai		19a. Informant's Name/Relations			19b. Mailin	g Address (Street	and Numbe	er or Rural Rout	e Number, (City or Town	, State, Ziç	Code)	
	and 2 Health em 27 ther tr		Ruth N. Lancas 20a. Method of Disposition	ster/spouse	1001 71		20 Mile	Lane					1545	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S	3 Removal from State		e of Dispos etery, crem	sition (Name of atory or other pla	ce)	Date	2	20c. Location	1 - City or	Town, State	
altir	permit. P Departm Importar any injur		21. Signatur Funeral Servi e I	icenso///		22.	Name and Addre	ess of Facilit	ty					
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			23a. Part . Enter the disease, or shock, or heart failure. List of Immediate Cause (Final)	complications that cause only one cause on each lin	d the death. De.	Do not enter	the mode of dyli	ng, such as	cardiac or resp	iratory arres	st,		Approximat Interval Bet	ween
~~	Physician/ Medical		disease or condition resulting in death)	a. Cere	a consequence	blee	elry						Onset and I	
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3876	ath certificate be attending physici for use as the bu	/Mec	IF FEMALE:	025 16.000 0.450000				CE	KIIIIO					
Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the bi	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Fetal de	eath 3 🗌	Ectopic pregnan Other (specify)	су				Date of del Month	-	'ear
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ords	v requires the been signer should be	letec											robably 4	
of Vital Records,	The law ate has page 2 :	Completed								4a. Was an autopsy perform	ned?	prior to o death?	topsy findings a completion of c	
alF	ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. P	lace of Dea	th (Check only o		No	1 L Yes	2 No	
F <	Shysic this ce al dire	ျ	1 X Yes 2 Z No		ient 2 🗆 ER/		3 DOA Oth	ier: 4 XNu	ursing Home 5	Resider	nce 6 🗆 Ot	her (Speci	ify)	
0	ng fter ine	cate	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig		y, Year)	b. Time of injury	28c. Injur worl		. 1	escribe how	v injury occu	rred		
Division	r Attendii er death. ector ; Af by the fu	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be		, farm, stre		165 2 🗆	28f. Lo			ber or Rui	al Route Numb	er,
ă	Hospital or 24 hours afte Funeral Dire sted filled in b									ity or Town,	,			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the to	Medical	(Check 2 L. Medical E	Physician: To the best of xaminer: On the basis of e Nurse Practioner: To the	examination and	id/or investi	ation, in my opini	on, death or	ccurred at the tin	ne, date and	niace and d	lue to the c	ause(s) and mai	nner stated.
	To the To the Comp	2	29b. Signature and title of certifier	001			29c. Licens	e number	_	29	d. Date sign	ed (Month	, Day, Year)	
			women	ekshir	MD		000	0553	325		oct	04,	2012	
1			30. Name and address of person v	who completed cause of c	leath (Item 23a	a) (Type, Pr	int) walk	Rel C	amhen	lund	MD.	100	2	
	Stat Registra		31. Date filed (Month, Day, Year)	327 Registra	ar's Signature	La	as I	., -				-13		
	Healstra	ar .	מע ויווו	/		C 20 City	A COURT							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 20 10 Liberto 1455 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Battimore, MD N/AUniversity of Maryland Medical If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 216 40 0659 1 🗆 M 2 🗓 F Director 70 Maryland 01/10/1942 at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Numbe 10 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1314 Williams Street 21230 U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 0 þ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. nan "natural", Medical Exan Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the McCormick & Company Purchasing Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Shiflett Jeannette Mussello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important; If item 27 is any injury or Art Baltimore, Maryland 21230 Doris Anderson / Sister 37 E. Heath Street 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 10/26/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Gonce Funeral Service, Leume 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, decomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CERTIFICATION APPROVED BY METICAL FRAMINER Physician Hu Pox la disease or condition) Medical resulting in death) as a consequence of Examiner cancer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Muocardial burial-trar resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 the use as ding IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the a 9 Unknown ed by the been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ coronary artery diseas 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an thepertunsion page 2 has autopsy performed Yes 2 certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural 2 Accident 10/5/12 Fall out of nheelchair 1 Yes 2 🐼 No Investigation UNK 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Boute Number, City or Town, State) BUTING AND STATE OF THE STATE OF 4 Homicide determined Nuvsing Home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 1720303811 MD who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person

Kav

Date filed (Month, Day, Year)

OCT 2 6 2012

22

South

St

Greene

32. Registrar's Signature

Baltmore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October T. Lutwack 8:30 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Autumn Assisted Living Cockeysville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2**X**) F Months Hours 3/30/1916 96 Connecticut Director 042-03-6397 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland by Funeral Director Maryland Baltimore Towson 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 104 Kenilworth Park Drive Apt 3 B U.S.A. 21204 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant. If item 27 is marked other than "natural", or items unry or other traumatic event, the Medical Examiner muny or other traumatic event, the Medical Examiner muny or other traumatic event, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Taylor 2 Florence Rutherford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Longbrook Road Lutherville, Maryland 21093 Penelope S. Fallon / Dtr 1102 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10/26/2012 Towson, Maryland 21. Signa of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition Physician milune ීත Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sequential descriptions). Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 <Physician/Medical the as attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? for Month Year ate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown vetive Polmanary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No after death.

Director: After this certification by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I pleted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the comple 29b. Signature and title of certifie

State

Registrar

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32. Register's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1425808

29d. Date signed (Month, Day, Year)

10/25/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18,20b, perFH, G933,11/9/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 Virginia 6:10 Vee Lynagh Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Gaithersburg 23700 Woodfield Road If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) Months Davs Hours Min. 579-38-3179 Director 1 M 2 X F **Yrs** August 3, 1928 Illinois Usual Residence of Decedent 28a-f shov 10c. City. Town or Location 10d. Inside City Limits 10a. State the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Rockville Montgomery 10e. Street and Number 0 10g. Citizen of What Country? items 23a Funeral 20853 United States 14019 Bardot Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or <u>م</u> 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Christian Gift Store 12 18. Mother's Name (First, Middle, Maiden Surrage)
Tanice Meredith Practner Be 17. Father's Name (First, Middle, Last) Paris Manaford Brickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7098 Garden Walk, Columbia, Maryland 21044 Kathy Lynagh Berge / Daughter Baltimore, 1 Date 11/3/12 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 30, 2012Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Barrell fette M01305 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Atherosclerosis disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician at the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ρ Month Year Pregnant at time of death ed by the a 1 ☐ Yes ∠ u g ☐ Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 X Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform yeriormed? Yes_ 2 🔼 No certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Son's Residence Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA ည After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? death. ☐ Accident ☐ Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 3 [29b. Signature ap 29c. License number 29d. Date signed (Month, Day, Year) October 25, 2012 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, M.D. 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State OCT 2 6 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 16a per 1h g932 10-26-12 vt.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Country) Director 110-10-6302 1 X M 2 □ F 92 10/28/1919 NY Usual Residence of Decedent 28a-f shov 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Directo 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with 1 Fleath and Mental Hygiena. item 27 Is marked other than "natural", or items 23a Funeral 5833 PARK HEIGHTS AVENUE 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 **FORMAN** — Foreman MATTRESS CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ LUBLINSKY RAE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 CANDLEMAKER COURT, #204, PIKESVILLE, MD 21208 HARVEY LUBLINSKY/SON injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of I Important: If its any injury or of once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 10/25/2012 RANDALLSTOWN, MD 21. Signature of Fune 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetand Death Immediate Cause (Final Physician/ theresc disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of Exami use as the burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physicien Physician/Medical certificate ba Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo or Attending Physician: The law requires that the death Day 5 Other (specify) 1 Yes 2 9 Unknown datached 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ba Division of Vital Records, 2 No 3 Probably 4 Unknown baan si Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funaral director, page 2: autopsy performed? 1 🗌 Yes 2 🗌 No 25. Was case referred to predical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗆 Yes 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 31. Date filed (Month; Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Serenity May Moral	es S	tate of Marylar	nd / Departmer	nt of Healt e of Death			2 N I	2 3451
Physician/	Registrar 1. Decedent's Name (First, Midd	dle,Last)	Ochineat	- Or Death		2. Date of Dea		3. Time of Death
	Serenity May					Month October 2	Day Year 1, 2012	0645 hrs
	4a. Facility Name (if not instituti				own, or Location of I	Death	4c. County of D	
	Johns Hopkins Bayvi			Baltim		0.41 10.0		N/A
Funeral Director	5. Social Security Number		. Age (In yrs. last birthd	Months	r 1 Year If Under 2 Days Hours	Min. 8. Date of Bir	th(MM/DD/YYYY) 9 Fo	oreign
Birestor	774-15-7946 Usual Residence of Decedent	1 M 2 KF		Yrs. 1	17	9/4/	2012	Country) MD
any	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
2	MD N/	A	Baltim	ore				1 X Yes 2 No
the Maryland t or 28a-f show tified at once. Director	10e. Street and Number			10f. Zip	Code	1	0g. Citizen of What (Country?
the M tiffied Dir	3324 Foreste	r Ave.		212	24		USA	
r death with or items 23 cmust be no Funeral	11. Marital Status				nt of Hispanic Origin / Cuban, Mexican, P	? (Specify Yes or No	- 14. Race - A White, et	merican Indian, Black,
or ite	1 Never Married 2 N	1 Yes	2 X No			derio racari, etc.)	Nativ	e American
rs afte	15 Decedent's Education (Co.	vorced If Yes, Give Year or Dates:	completed) 16a De		No specify: Occupation (Give kin	ad of work done	Specify:	ndian
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exan Completed	Elementary/Secondary (0-12		du		king life. DO NOT us		TOD. Raild of Busine	755/11 ldusti y
D36 thin 7 re. than edica	N/A	N/A		N/A			N/A	
5-06 will led will led will led will led will led will let will le	17. Father's Name (First, Middle					Name (First, Middle, I	Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica fo Be Comple	Luis Kirk M				1	Lynn Ko		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relation Reva L. Lock					er or Rural Route Num e. Balti		
, MD and 2 sho ealth and cm 27 is reaumati	20a. Method of Disposition	Tear-Moth		Disposition (Nam		Date	20c. Location - Cit	_
Baltimore, pernit, Pages I at Department of Hee Important: If ite	1 Burial 2 Cremation		n State crematory	or other place)				
Itim it. Pa, rtmen rtant y or o	4 Donation 5 Other S 21. Signature of Funeral Service		Bayvie	W Crem	atory [0/29/201 March F	2 Baltin	ore, MD
Ba Derm Depa Impo	21. Orginalar di vicini	K- Inc	ر ا	1101 E	. North	Ave. Ba	ltimore,	MD 21202
Physician	23a. Part I. Enter the disease, o		ised the death. Do not e				-	Approximate Interval
(Medical)	failure. List only one cause Immediate Cause (Final diseas	C	Jnexplained	Death 1	in Infanc	У		Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a c						
<u> </u>	Sequentially list conditions,	b Due to (or as a c						
ted 1 nnsit Examine	if any, leading to immediate cause. Enter Underlying Cause		onsequence or).					34
sit d	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
Se ta se	X UNPENDED	d.	7 18 ner fh	α 932 10)_26_12 v	+		
e be exe ysician burial -	L	23a, 27,	,18 per fh 28a-f,per m	e, g934	12-17-12	sm	Look barrack	
Box 68760, e death certificate by the attending physic of for use as the bur hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2	Fetal death	3 Ectopic p	regnancy	23d. Date of deli Month	Day Year
ox 6 ath cer attendi		known	nt at time of death 5	Other (Speci	fy)			
). Box 68760 the death certificate by the attending physiched for use as the burby sician/Me	Part II. Other significant condi	9 Unknow		41	an an airea ia Bart	, I age Did to	.hanna anatribut	e to the cause of death?
P.O. es that the igned by be detach		uons contributing to t	death but not resulting in	i the underlying	ause given in Part		2 ✓ No 3	
w requires to w requires to seen sign should be pleted to pleted the seen states and the seen sign should be seen sh								e autopsy findings available
Records, The law requires ficate has been sign, page 2 should be Completed						autop		to completion of cause of
Reficate Con					0.01	1 ✓ Yes		Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sided in by the funeral director, page 2 should bertification: To Be Completed	25. Was case referred to medic examiner?	Illoanitely -	patient 2 🗸 ER/Outp		6.Place of Death (C	Nursing Home 5	Pasidanca 6 0	Mhar
Ing Physi Ing Physi After this funeral di	1 Yes 2 No 27. Manner of Death	28a. Date of	f Injury 28b. Tin		8c. Injury at Work?		now injury occurred	uror.
on on ath.		iding FA 10	Day, Year) 0-21-12 fd 6	• 25 am	1 Yes 2 N	unknown		
vision or Atteno fler death Director: in by the		28e. Place	of Injury - At home, farm	, street, factory,		28f. Location (S	Street and Number o	r Rural Route Number, City
Division (spiral or Attending nours after death, filled in by the fun Certification	Odicide ove	ermined (Specify)	Found In He	otel roo	m	#112 Ba	ltimore,M	laski Hgwy. D.
e Hosy of Functional Call	(oncor only	•	of my knowledge, death			e, and due to the caus	e(s) and manner as	stated.
Fo the comp		and manner sta	examination and/or inve ted.			rred at the time, date		
Σ.	29b. Signature and title of certif	er /		29c.	License number		29d. Date signed	
UGME					O.C.M.E.	· · · · · · · · · · · · · · · · · · ·	October 21, 2	U I Z
	30. Name and address of perso Mary G. Ripple MD.		of death (Item 23a) edical Examiner	900 W Ball	imore Street F	Saltimore MD 21	223	
State			istrar's Signature	JUD VV. Dail	orc otreet, E			
Registrar	111'1 11 6		4	2				
DHMH 17 Rev 1/2001			OFFIC	SINAL				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10 03pm Dorothy W. Matarozza 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL Rosedal Baltimore 8. Date of Birth (Month, Day, Social Security Numbe If Unde If Under 24 Hrs. 7. Age (In vrs. last birthday Year **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min. 220-18-7342 Director 85 1 M 2XXF December 18, 1926 Yrs Baltimore, Maryland Usual Residence of Decedent 23a or 28a-f show with the Maryland 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f shc edical Examiner must be notified at 10d. Inside City Limits Funeral Director Baltimore Nottingham Maryland 1 Yes 2 Who 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Sagebrush Court 21236 United States and 2 should be filed within 72 hours after death Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michaelina Wojtsyiak Walenty Wilczynski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7780 Poplar Grove Road Severn, Maryland 21144 19a. Informant's Name/Relationship (Type, Print) Robert Matarozza (Son) or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State October 25, 4 Donation 5 Other (Specify) St. Stanislaus Cemetery 2012 Dundalk, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Eacility

Evans Funeral Chapel & Crematice

8800 Harford Road Parkville, N

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or result failure. List only one cause on each line. Name and Address of Eaclity
Evans Funeral Chapel & Cremation Services Parkville 8800 Harford Road Parkville, Maryland 21234 Interval Between Onset and Death Immediate Cause (Final InTracrania Hemorrhag disease or condition iThin 24 ho Medical resulting in death) Due to (or as a consequence of): **Examiner** Anticoaa coumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the funeral Director of the f Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? 2 🗆 No ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending unknowA Fell in Kitchen 10-21-2012 Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) md 21236 sagebrush ct nottingham Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D67626 of death (Item 23a) (Type, Print) 30. Name ar address of per 9000 FRANKLIN SQUARE DR Balto md ennife ompson 31. Date filed (Month, Pay,

State

Registrar

Dorothy

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mataro

Registrar's Signature

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 8 State of Maryland / Department of Health and Mental Hygiene State
Registrar 3451 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Berton McCauley 2012 10 $04:15 \text{ a}^{M}$ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 3804 Hadley Square East Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Min. Months Hours 579-46-6875 98 1 **X** M 2 □ F Dec. 20 1913 Minnesota 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3804 Hadley Square East 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dentist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Berton McCauley Flora Bourassa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Overbrook Road, Baltimore, Maryland 21239 Brian McCauley / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 11/02/2012 | 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State New Cathedaral Cem. 10/29/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Lce 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or com Nicott ins that caused shock, or heart failure. List only one cause on each line hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death rena month disease or condition resulting in death) Due to (or as a consequence of): omstate motastatio Canlor URACI

Physician/ Medical **Examiner**

Physician/

Medical

Director

Funeral

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Completed

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Director

ral", or items 23a or 28a-f s Examiner must be notified

"natural".

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

the Medical

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760-c

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 2,6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raven

Blud

32. Registra's Sign

State

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of);	icit Confi			y ca, j
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of a	al death 3 - Ectopia			23d. Date of deli Month	very Day Year
	Part II. Other significant conditions con	atributing to death but not res	ulting in the underlying	g cause given in Part I.			the cause of death?
Completed					24a. Was an autopsy performed? 1 □ Yes 2 🔀	prior to c death?	opsy findings available ompletion of cause of $2 \square$ No
Be	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
မ	1 🗆 Yes 2 🔀 No		ER/Outpatient 3 🗌	Other: 4 Nursing F	lome 5 🗷 Residence	6 Other (Special	fy)
Certificate:	27. Manner of Death 1. ★ Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	
	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto)	ory, office	28f. Location (Street a City or Town, State	nd Number or Rura te)	al Route Number,
Medical	I (Check 2 ☐ Medical Examine	cian: To the best of my knowler: On the basis of examination Practitioner: To the best of m	and/or investigation. In	n my opinion, death occurred	at the time, date and place	ce and due to the c	ause(s) and manner stated

29c. License number

MN

DO065145

21239

29d. Date signed (Month, Day, Year)

Oct -23-2012

Olga Lurye, MD

DHMH 17 Rev 06-2011

Registrar

Battimore

Frances Ann Merryman As Facility Name (if not institution, give street and number) As Facility Name (if not institution)	3 4 5 1 (
Frances Ann Merryman 4a. Facility Name (first, Middle, Last) Francet Director Frances Ann Merryman 4b. City, Town, or Location of Death Saltimore France Sann Merryman 4c. County of Death Saltimore 4c. County of Death Saltimore France Sann Merryman 4c. County of Death Saltimore France Sann Merryman 4c. County of Death Saltimore France Sann Merryman 4c. County of Death Saltimore 4d. Division of What County 4d. Division of What County 4d. Morth Sann Americal Saltimore 4d. Morth Saltimore 4d. Morth Sann Americal Saltimore 4d. Morth Saltimore 4d	
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Maryland Baltimore County Lutherville 10f. Zip Code 10g. Citizen of What Country 11105 Greenspring Ave. 10f. Zip Code 10g. Citizen of What Country 1110 Greenspring Ave. 1110	Maryland
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. 14. Race - American White, etc. 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired) 16b. Kind of Business/Ind. 17. Father's Name (First, Middle, Last) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired) 16b. Kind of Business/Ind. 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden	0d. Inside City Limits Yes 2 X No
3 Widowed A Divorced If yes, Give Year 1 Yes, Give Year 1	
3 Widowed A Divorced If yes, Give Year 1 Yes, Give Year 1	
Physician Medical Examiner Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart And the faiture List only the cause on each line.	
Physician Medical Examiner Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart And the faiture List only the cause on each line.	ŕ
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Physician Medical Examiner Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart And the faiture List only the cause on each line.	enter, P.A.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death). Last consequence of its cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death). Last cause in the conditions of the co	Approximate Interval Between Onset and
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercise resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):	Death
(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
MENDED AMENDED	
FFEMALE: 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery April 1	Year
Worth Day IF FEMALE: 23d. Date of delivery See a part of the past 12 months? If Yes 2 No 9 V Unknown Other (Specify) Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 23d. Date of delivery Amended 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Other (Specify) 9 Unknown 23e. Did tobacco use contribute to the	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the 1 Yes 2 W No 3 Probable	
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Deformed? death?	2 No
25. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Place of Death (Check only one) 28. Place of Death (Check only one) 4 Seximiner? 1 ✓ Yes 2 No No Other 4 Nursing Home 5 Residence 6 Other:	.,
The state of the s	
24a. Was an autopsy performed? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 3 Occur	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	Day, Year)
30. Name and address of person who completed cause of death (Item 23a)	
Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Month, Day, Year) Registrar OCT 2 6 2012 Registrar	

DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene

CEDA MAILE		State of Maryland / Dep 1-For State Registrar	ertificate of Death	nd Mental Hygiene	2017 Reg. No.	2 3451
Physicia Medical Exami		Decedent's Name (First, Middle,Last) Reba R. Ma:	rtz	2. Date of D Month October		3. Time of Death 0130 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, o	or Location of Death	4c. County of Deat	h
Funeral		Baltimore Washington Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs	Glen Burni . last birthday) If Under 1 Ye		Anne Arunde Birth(MM/DD/YYYY) 9. Bi	
Director		219 01 2116 1 M 2XF 93	Yrs. Months Da		. Forei	
ĥ			ty, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	힏	Maryland Anne Arundel	Glen Burnie			1 Yes 2 No
he Mary or 28a	Director	10e. Street and Number 258 Woodhill Drive Apt. B	10f. Zip Code 210	161	10g. Citizen of What Cou	ntry?
th with t	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	U.S. 13. Was Decedent of H	lispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.)	<u></u>	ican Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "matural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	by Fur	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X			hite
hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupa during most of working life		16b. Kind of Business/	Industry
036 ithin 72 ne. r than	Completed	12	Homemaker		Own	Home
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)	1 -	18.Mother's Name (First, Middle Ethel	e, Maiden Surname) (not ava	;1ab1a)
212 ould be d Menta s marks	To Be	Joseph Richar 19a. Informant's Name/Relationship (Type, Print)		et and Number or Rural Route N		•
MD and 2 sho alth and 2 sho am 27 is		Ronald Morrison / Son 20a Method of Disposition 120b	258 Woodhill Place of Disposition (Name of ce	Dr. Apt. B G.	len Burnie,	
Baltimore, MD 21215 permit. Pages land 2 should be filed Department of Health and Mental Hy Important: If iten 27 is marked o		1 Burial 2 Cremation 3 Removal from State	crematory or other place)		.2 Baltimore	
altin		4 Donation 5 Other Specify: P1O 21. Sign tire of Funeral Service Licensee	oreland Mem. Par 22. Name and Addres		neral Service	
	4	23a. Part 1. Enter the disease, or complications that caused the deat		hie Highway Ba		yland 21225 Approximate Interval
Physician Medical	15	failure. List only one cause on each line.	Cardiovascular		arest, shook, of flear	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence		DISCASE		
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence cause Finter Underlying Cause	of):			
J = =	Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	of):			-
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical E	d. AMENDED AMENDED 23a, 27, 1	per me,g933 11-	20-12 sm		
760, cate be physici the buri	/Wed	IF FEMALE: 23c. If yes, outcome of pre-			23d. Date of delivery	,
Box 6876: death certificate the attending phy of for use as the b	<u>ē</u>	past 12 months? 4 Pregnant at time of d	2 Fetal death 3 death 5 Other (Specify)	Ectopic pregnancy	Month [Day Year
that the deat ned by the att detached for	Physic	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not	resulting in the underlying cause	given in Part I 23e Did	tobacco use contribute to	the cause of death?
, P.O. res that the signed by be detacl	[출		researing in the underlying educe		es 2 No 3 Prob	
of Vital Records, Ing Physician: The law requires the true this certificate has been significate director, page 2 should be	Completed				opsy prior to d	topsy findings available completion of cause of
Rec The la ficate h	8			1 ✓ Yes	formed? death? 2 No 1 ✓ Ye	s 2 No
Vital F hysician: '	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient 3 DOA	of Death (Check only one) Other Nursing Home 5	Residence 6 Other	
C# 3 ~ 4	-1	27. Manner of Death 28a. Date of Injury (Month, Day, Year)			e how injury occurred	
Division tal or Attendii rs after death. al Director: A	ficati	2 Accident Investigation 28e. Place of Injury - Ath	nome, farm, street, factory, office t	Yes 2 No building, etc. 28f. Location	(Street and Number or Ru	ral Route Number, City
Divis spital or At ocurs after d seral Direct filled in by	Certification	4 Homicide determined (Specify)		or Town,		
0 ~ ~ ~	Medical	29a. Certifier Check only 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination of the basis of the				
P P P P P	ğ.	and manner stated. 29b. Signature and title of certifier	29c. Licens		29d. Date signed (Mor	nth, Day, Year)
~		G Mund	O.C.	M.E.	October 24, 2012	2
\wp		30. Name and address of person who completed cause of death (Iter Zabiullah Ali, M.D. Assistant Medical Examine	r 900 W. Baltimore Stre	eet, Baltimore, MD 21223	3	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar Signat	all			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24, Robert Eugene Mason 2012 11:05 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 611 Brightwood Club Drive Baltimore Lutherville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours June 7, 1917 Director 422-16-8899 1 X M 2 D F 95 Alabama Yrs permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland D partment of Health and Mental Hyglene. It portant: If item 27 is marked other then "neturel", or items 23a or 28a-f show an yinjury or other traumatic event, the Medical Examiner must be notified at on 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 No Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 611 Brightwood Club Drive 21093 U.S.A 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Specify: White Year or Dates. WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marvin Mason Helen Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Mason, M.D.-son 217 Paddington Rd., Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv Corp 10/26/12 Towson, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FOOT CARDIOVASC disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi): To the Hospital or Attending Physicien: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🐼 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death I Director: After to id in by the funeral 28b. Time of 28c. Injury at 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a
To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #209 NOZTAN 9105

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Registrar

31. Date filed (Month, Day, Year)
OCT 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 Day Year Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner Grove Var mon gers bur 022162 9. Birthplace (State or Foreign Country) Austria Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 07/28/1919 Days Hours Min Director 1 M 2 □ F 084-16-9426 Yrs Usual Residence of Deceder 10c. City Town or Location 10d. Inside City Limits within 72 hours efter death with the Maryland or then "neturel", or items 23e or 28e-f sho the Medical Examinating must be notified at Director 1X Yes 2 ☐ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 King Farm Blvd #414 20850 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 \(\overline{\text{Ves}} \) Yes 2 \(\overline{\text{NoWW}} \) If Yes, Give Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pege 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ent: If Item 27 is marked other then 'ury or other traumatic event, the Mu Elementary/Secondary (0-12) College (1-4 or 5+) Foreign Service Officer Federal Government 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Muller Anna Sommer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helga Powdrell / Daughter 3714 Oak Hill Way, Fairfax, VA 22030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Importent: If it any injury or o once, 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2012 Chesapeake Crematory Beltsville, MD 012 Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall COOL Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. J Approximate 5 Immediate Cause (Final Physician/ ease or condition J Medical resulting in death) Examiner pertensive Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine m O use as the burlel-trensit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificete be executed Due to for as a consequence 6. Box 68760 ete has been signed by the attending physicien pege 2 should be detached for use as the burle Physician/Medical 17 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? $\mathbb{N}_{\mathcal{U}} \setminus \mathcal{E}$ Division of Vital Records, P.(Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death, Funerell Director: After this certificete has to letely filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 N 88 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No 12 23:30 PM Investigation while going to bathwom 3 Suicide 6 Could not be 28f. Location (Street and Member of Rural Route Number City or Town, State)

70 | King Farm DLV mD 208 28e. Pacs of Injury - At home, farm, street, factory, office building, etc. (Specify) at Farm MD 208.30 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check within 2 To the I only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 7250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Dr. Rochille 9901 Bridgit um kara Nosilost 31. Date filed (Month, Day, Year) State 6 Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Medical John Michalkiewicz. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5107 Sipple Avenue Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-16-1458 (Month, Day, Year) Hours Director 1 🖳 M 2 🗆 F 89 Dec. 24, 1922 Maryland ge 1 and 2 should be filed within 72 hours efter death with the Maryland nt of Health and Mantal Hygiane.

E. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinating that the filed at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Md. City 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 5107 Sipple Avenue 21206-5229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 √2 Yes 2 □ No If Yes, Give ð 1 ☐ Yes 2 ☐xNo Specify: Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th <u>Esskav Meats</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OCTOBER Michalkiewicz Eva Patro 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hedwig E. Michalkiewicz 5107 Sipple Avenue Baltimore, Md. 21206 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct8ter permit. Pege 1 Department of Importent: If it any Injury or o 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus Cem 27,2012 Baltimore, Maryland 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician ENN STA 6 E Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the ettending physicien end thed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the e Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, P. 31. Date filed (Month, Day, Year) State Registrar ✓ DHMH 17 Rev 06-2011

AMEND #25, PER ME Cetate of Maryland TPT Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Oct William Ralph Noble Jr. 16 3:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year) Hours 218-58-3124 Director 1**X** M 2 🗆 F 60 11-24-1951 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a or 28e-f showens, injury or other traumatic event, the Medical Examination. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 17 Bancroft St. USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2X☐ No Specify: Specifiwhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Parts Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernice Hipsley William R. Noble Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna F. Noble-wife Bancroft St., Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 10/16/12 Winfield, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral & Cremation Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to implement cause. Enter Underlying Examiner Due to (or as a consequence of): MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events CERTIFICATION APPROVED BY Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 L 9 Unknown Yes 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 Ø No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 No 1 🗌 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA Division of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St, CNTOR 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Blodman Elizabeth 01dfield 1049 AM Medical 2012 NEROTER 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF DALTI MONE n/a BALTIMORE 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 236-48-5290 Director 1 🗆 M 2 🔀 F 79 Jan. 25, 1933 Virginia 10a, State 10b. County 10c. City, Town or Location death with the Maryland items 23a or 28a-f sho er must be notified at Director 10d. Inside City Limits Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10535 York Rd. #117 21030 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMA KEY 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John R. Breeden Lacy Vaught 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy J. Oldfield/ Son 207 Sandy Pond Road Lincoln, MA. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit, Page Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Co. 10-26-12 Towson, MD. 21. Signature of Funeral/Service License ^{22. Na}Ruck^{Ad}Towsoni^NFuneral Home, 1050 York Rd. Towson, MD. Inc. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiration arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Brain Iniu raumanc Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intrincidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): HIFICATION Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funerel Director. After this certificate has b completely filled in by the funeral director, page 2 si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28d. Describe how injury occurred found down Certificate: 28b. Time of 28c. Injury at 1 Accident 5 Pending work?
1 Yes 2 No and unresponsive by Maintenance worker WY Known 0117112 Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Cockeysville, MD 10535 York Road At home Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature a 29d. Date signed (Month, Day, Year) RESOOD -MO OCTOBER 18 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAWE SYUM OUA MD SINAI HUSPITAL OF BALTIMONE 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

OLDPIEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2012 IKOWS! 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE GENESIS ELDRCARE PERRING PKWY. PARKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/12/1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** Months 1**X** M 2 □ F 91 MARYLAND 214 18 0597 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mental Hygene.
wart if item 27 Is marked other than "natural", or items 23a or 28a-f show and it in the order traumatic event, in. "Modes! Examiner mails to indiffice at any or other traumatic event, in. "Modes! Examiner mails to indiffice at 1 ☐Yes 2 X No MD BALTIMORE ROSEDALE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 USA OLD PHILADELPHIA ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 11. Marital Status illed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE If Yes, Give Year or Dates: Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEER DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GERTRUDE** WARNER PETE OLKOWSKI ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BELINDA AVE BALTIMORE, MD 21206 RICHARD C. OLKOWSKI/SON Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/25/12 BALTIMORE, MD PARKWOOD CEM 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buris Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year ☐Yes 2 100 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performed 2 12 No 2 12 No 1 TYes 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c 1 ☐ Yes 2 ☑ 1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury 5 Pending investigation 1 Natural ithin 24 hours after death.

the Funeral Director: Aft

mpletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Name and address of person who completed cause of death (Ifem 23a), (Type, Brint) Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Or Canoudo K15 Month 10 Physician/ 7:00 oforal Medical 4a. Facility Name (if not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A University Of Maryland Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Social Security Number **Funeral** (Month, Dav. Year) Months Davs Hours 092-44-8291 63 Director 1 X M 2 D F Yrs Oct. 16, 1948 Greece Usual Residence of Decede 28a-f show 10b County 10c. City Town or Location 10d Inside City Limits at 10a. State Director Chestnut Hill Cove be notified Marvland Anne Arundel 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 23a Funeral U.S.A. with 21226 must I 939 Chestnut Manor Court items death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, "natural", or Item edical Examiner n Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces? þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Specify:White If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Produce Market N/A Self Employed permit. Page 1 and 2 should be filed w Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Amalia Orfanoudakis (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 929 Chestnut Manor Court Chestnut Hill Cove Md 21226 Emily Orfanoudakis (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Glen Haven Mem. Pk. 10/19/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
IcCully-Polyniak Funeral Home, P.A.
Collynoid Pasadena, Maryland 21. Signatur of Fineral Service Licensee Kevin E Ecker 2 M0017523a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease Coronary disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Onderlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and -tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death been signed by the a should be detached t g Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has autopsy performed?
1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 No or Attending Physician: The safter death.

Director: After this certificate by funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) e i examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature a 1215195662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 229. Greene 9t, Baltimon, Thomas Kicin Registrar's Signature 31. Date filed (Month Day, Year) 32. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Richard Piatt Physician/ October 7:27 A.M 13, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick 8. Date of Birth (Month, Day, Y Aug • 26, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 577-42-1050 81 Aug. Director 1 XM 2 □ F Pennsylvania 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland notified at Director Huntingtown Calvert 1 Xes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 23a 1603 Meadow Oaks Lane 20639 United States items ; Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status event, the Medical Examiner Black, White, etc Armed Forces? 1 XYes 2 No
If Yes, Give Korean War
Year or Dates. "natural", or ð 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. U.S Government Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Piatt Marie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 is 1603 Meadow Oaks Lane, Huntingtown, MD 20639 Agnes T. McLaughlin/Friend 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Geo. Wash. University
Medical Center 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2 Cremation 3 Removal from State Oct. 15 Washington, D.C. 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facilit Columbia Mortuary Services, P. A. /M00969 0= 9013 Annapolis Road, Lanham, MD 20706 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Prejoician/ NEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CORONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated so or injury) Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ACU TO physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 HYPERTENSION yes, outcome of preg*n*ancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death g Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an nis certificate has bull director, page 2 s autopsy Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: ပ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1
Yes 27. Manner of Death 28b. Time of Certificate; 28d. Describe how injury occurred After injury 1 Natural 5 Pending 2 🗌 No Investigation Accident within 24 hours after death

To the Funeral Director: A
completely filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sidhu

32. Registrar's Signature

HOSPHALL

29c. License number

29d. Date signed (Month, Day, Year)

Prince Frederick mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #28A-F, PER EM G932 16/24 12 TRT Department of Health and Mental Hygiene For State Registrar 34528 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ortober 12:43 PM 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Northwest Randallstown Hospital Battimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 215.23.1902 Director 1 □ M 2 VF Yrs r than "netural", or items 23e or 28a-f show the Medical Examiner rust be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2932 Fairview Road 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?,

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married <u>م</u> Specify: African Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiane. Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Officer parmit. Paga 1 and 2 should be filed wit.
Dapartment of Heelth and Mental Hygiar important: if item 27 is marked other t.
any injury or other traumetic event, the once. 12tharade Year 'orrectional Detention Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carter Shelley Warren Polston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Baltimore MD 21207 Shellev Carter Fairview altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Laurel, MD Maryland National 10/20/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral services Road Randallstown MD 21123 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ AnoxII disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Minutes Sequentially list conditions, If any leading to in recland cause. Enter Underlying Cause (Disease or injury PROVED BY MEDICAL EXAM Examiner this certificate has baen signed by the attanding physician and ral diractor, page 2 should ba detached for usa es tha burlal-transit sthma Physician: The lew requires that the death certificate be executed that initiated events TJEK ATION AT resulting in death) Last Due to (or as a consequence of): Physician/Medical Nours Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 No 5 Other (specify) Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by History Allergens with Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown To the Hospital or Attending Physician: The lew requires within 24 hours after death.

To the Funeral Director After this certificate has been sill completely filled in by the funeral director, page 2 should Pulmonary From Allergens 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Arrest perform 2 🗆 No 1 Tes Be (25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2ا 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural SUBJECT INGESTED ALLERGEN(S) 1 ☐ Yes 2 🗓 No Accident Investigation 10/8/2012 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number, City or Town, State) FD 5401 OLD COURT determined RD RANDALLSTOWN, MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death consumed at the time, date and clace and due to the cause(s) and manner stated 29b. Signature and title of certifier Kerzo October 13, 2012 D 66166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Suite 72 IKram Baza 801 21701 101 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan				Mental Hy	giene 20	112	34529
		_	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeath	2. Date of De	Reg. No.		3. Time of Death
	Physicia		, and the state of	Jacob Derrell Pa	rker			Month	Day	Year 2012	17 04 M
	Medic Examin		4a. Facility Name (if not institution, give stree	et and number)		4b. City, Town, or	Location of Dea		4c. County		
تمرسه			The Johns Hopk				NOTE	City			
	Funeral Director		5. Social Security Number n/a Usual Residence of Decedent	7. Age (<i>ln yrs. la</i>	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min 9 48			9. Birthpla Countr	lace (State or Foreign Maryland
	and show Lat	or	10a. State 10b. County	10c. City	, Town or Loc	ation				10	Od. Inside City Limits
	Maryla 28a-f	irect	MD				Baltimore				1 X Yes 2 □ No
	h the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of		ry?
	ms 2:	Funeral Director	2736 Riggs Avenue	Was Decedent Ever in U.S	13 \	/as Decedent of H	21216	Specify Ves or No-	14 Pec	USA ce - America	n Indian
ဖ	er de: or ite		1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No	If	Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		ck, White, et	
9	urs aff ural", al Exa	Completed by	· 3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 X No	Specify:		Specify	Bla	ack
15-	72 hoi n "nat ledica	nple	15. Decedent's Educa (Specify only highest grade o		(Give k	ent's Usual Occup ind of work done of NOT use retired)		orking	16b. Kind of B	Business/Indu	ustry
212	vithin giene. er thau the N		Elementary/Secondary (0-12) n/a	College (1-4 or 5+)	ine. DC		N/A			N/A	
nd	filed val Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surnam	ie)	
yla	2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	욘		ave Parker					ynita Greer		
altimore, Maryland 21215-0036	2 sh th ar trau		19a. Informant's Name/Relationship (Type, Tynita S. Parker / Mother	Print)	I	g Address (Street a Riggs Aven			-	State, Zip Co	ode)
re,	of Health of Health of item 27 r other tra		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of eatory or other place		Date	20c. Location	- City or Tov	vn, State
E	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 🔀 Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		ke Cremator		/26/2012	В	eltsville,	, MD
Balt	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Licensee	to a leash	34	Name and Address 1aryland Cre		vices, PO B	ox 1413 B	altimore	e, MD 21203
			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one care		n. Do not ente	r the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	hysician/	0. 1	Immediate Cause (Final disease or condition resulting in death)	Vein of (Saler	Malfo	rmatio	nc			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	. 10	-11-00				
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as consequ	ence of):	Part 17	mue				
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	2.30						-	l)
_	ate be executed ohysician and the burial-transit	dical E	resulting in death) Last	Due to (or as a consequ	ence of):						
200	cate b physic	ledic	d.								
Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 24 burns after death. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnand Other (specify)	у			ate of deliver onth [ry Day Year
O.	that th ned by e detai	by Pr	Part II. Other significant conditions contrib	outing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use cont	tribute to the	e cause of death?
ds,	quires en sig ould b	ted !						1 🗆	Yes 2 No	3 Proba	ably 4 🗌 Unknown
Records,	rsician: The law re s certificate has be director, page 2 shr	Completed						24a. Was auto perfo 1 🗆 Yes	osy		sy findings available npletion of cause of
<u>e</u>	sian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?			26. Pl	ace of Death (Ch		270 1101		
Ξ	Physic this ce	၉	1 ☐ Yes 2 💢 No	1 Inpatient 2			4 U Nursing	Home 5 Resi			
0	ding F th. After funer	cate	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🔲		28d. Describe h	now injury occurr	red	
Division of Vital	or Atten after dea Director: In by the	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At ho building, etc. (Specify)				28f. Location (S City or Tov	Street and Numb vn, State)	er or Rural F	Route Number,
	To the Hospital or Attending Physician: "In the Funeral Director: After this certification for the Funeral Director: After this certification place of the Funeral director, sompletely filled in by the funeral director,	edical	(Check 2 Medical Examiner:	n: To the best of my knowle On the basis of examination	and/or investi	gation, in my opinio	on, death occurred	at the time, date a	and place, and du	ue to the caus	se(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 ☐ Certifying Nurse Pr 29b. Signature and title of certifier	actitioner: To the best of m	iy Knowledge,	29c. License		place, and due to	29d. Date signe		
				+D		RES	000		Octobe	T 2	1 2012
			30. Name and address of person who comp	10		1800 Or	-leans	St Balt	imore	Mari	1 2012 pland 21287
	Stat Registra		31. Date filed (Month, Day, Fear) OCT 2 6 2012	32. Registrar's signat	park						•

			AMEND PI LINE B,	Type or Print in 25,27,28A-F State of Marylan	Black Ir PER ME Id / Depa	ndelible In G932 10 artment of I	k. Ensure /23/12 Ti lealth and l	All Copie Tental Hy	s Are Leg	ible.
			For State Registrar			tificate of L			Reg. No. 20	12 34530
I	Physicia		1. Decedent's Name (First, Middle, Last)	HGF.				2. Date of De Month	Day	Year 3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give si	reet and number)		4b. City, Town, o	r Location of Death	1 7 0	4c. County	12 000
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	Ir Under 1 Year	MDR If Under 24 Ars.	8. Date of Bir	th	9. Birthplace (State or Foreign
	Director		217-80-8325 Usual Residence of Decedent	M 2 □ F 39	Yrs.	Months Days	Hours Min.	(Month, De	6 73	Maryland
	yland •f show ed at	ctor	10a. State 10b. County Maryland		y, Town or Lo			100		10d. Inside City Limits
	the Mar or 28a e notifi	Dire	10e. Street and Number	Dal	LCTIIIOI	10f. Zip Code		Ĭ	10g. Citizen of \	1 ✓ Yes 2 No What Country?
	th with ns 23a must b	Funeral Director	1 South Payson			21223			USA	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ह	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 		Was Decedent of H f Yes, specify Cuba □ Yes 2 🗷 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	1	e - American Indian, sk, White, etc. :Black
15-(72 hou in "natu Medica	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give I	dent's Usual Occup kind of work done of O NOT use retired)	during most of work	ing	16b. Kind of Br	usiness/Industry
212	d within ygiene.	Be Col	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)		oloyed			Unempl	oyed
Maryland	be filed ental H ked ot ic ever	To B	17. Father's Name (First, Middle, Last) James Page				18. Mother's Nan Lillie		Maiden Sumame	2)
ary	and Me is mar		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or Rur			itate, Zip Code)
	and 2 s Health em 27 ther tra		Barbara Page/Si		2431		7 Court			ryland 21230
Baltimore,	Page 1 ant of B		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other place Cemeter		3-12		· City or Town, State
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licenses							Funeral Home re MD.21215
		Н	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the deat						Approximate
	Physician/		Immediate Cause (Final disease or condition resulting in death)	ASUR	ATTO	N				Interval Between Onset and Death
	Medical Examiner			or a consequ	uence of):	2	CHOKING			DWER
	ed sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due ty (or as a consequ	uence of):			1 19	puther BY N	EDICAL HAMINER
	executed an and rial-trans		that initiated events resulting in death) Last	Due to (or as a consequ	uence of):			CHILICATION	N APPROVED	
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Rec	The lav ate has page 2	Somp							ormed?	orior to completion of cause of death? 1 □ Yes 2 □ No
Vital	Physician: T r this certifica aral director, p	Be	25. Was case referred to medical examiner?	espital:		_ Oth	ace of Death (Chec			
of V	g Physer this	te: To	27. Manner of Death	1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun	4 ∐ Nursing Hey at		dence 6 ☐ Othe how- <u>i</u> njuny-ecourre	er (Specify) ON BOLUS OF
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Division	spital or A		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify HOSPITAL ian: To the best of my knowl	") ——————			BALT IMO	RE, MD	er or Rural Route Number, W. BALTIMORE ST
	the Hos nin 24 h the Fur npletely	Medical	(Check 2 Medical Examine		and/or invest	igation, in my opinio	on, death occurred a	t the time, date a	and place, and due	e to the cause(s) and manner stated.
V	Note of the state		29b. Signature and title of certifier	1.000 Day 1	110 E	29c. License	e number		29d. Date signed	(Month, Day, Year)
			30. Name and address of person who con	npleted cause of death (Item	23a) (Type, P	rint)	2207/		10/4	WP
	Stat	e e	HISON . K. S.	32. Revistrar's Signat	DFA-	P Boo	20 WES	IBAL	TOTRE	ET
	Registra		nct 262	012 Peneur	P. 19	Jan Jan				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 ^{Vea} 12 Physician/ 11:20 PM William Lloyd Poole Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Elkton Union Hospital 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth Social Security Number . Age (In yrs. last birthday) If Under 1 Year **Funeral** (Month Day Year) 64 Maryland Months Days Hours 1 □XM 2 □ F 48 212-78-6659 Director Usual Residence of Decedent or 28a-f show be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Colora MD Cecil 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code must be Funeral items 23a 21917 154 Mt. Rocky Lane hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces Black, White, etc. 9 1 Never Married 2 Married Yes 2 XNc ģ Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify "natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver 12 Be 18. Mother's Name (First, Middle, Maiden Sumame, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) Patsy Berchette Billy Poole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 154 Mt. Rocky Lane, Colora, MD 21917 Darlene Mohr / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/22/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cancer Pour i ian disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ρ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv has certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA မ this filled in by the funeral 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After injury (Month, Day, Year) Natural N 5 Pending 1 Yes 2 No 3 Suicide 4 Ho Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 L Medical Examiner; On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpleted

State Registrar DHMH 17 Rev 7/2009 (Check

29b. Signature and title of certifier

AUGUSTINE HERMAN HWY, SUITE A, CHESAPEAKEUTY, MD21915 32 Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHANMD

D0062190

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM#20b, perff, G933, 11/9/2012, WS
State of Maryland / Department of Health and Mental Hygiene

		_1	For State Registrar	Otate of Ivial	-	Certificate of	Death		Reg. No.	2012	34532
	Physicia		1. Decedent's Name (First, Middle, La					2. Date of Dea Month Octobe		2012	3. Time of Death 9:35 A M
	Medic	al	Klyne 4a. Facility Name (if not institution, gin	Francis	Peard		or Location of Death			ounty of Death	
	Examin	er	Kensington Park		munity		nsington		10.00	Montgo	- 1
Andrew C	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last birtho		If Under 24 Hrs.	8. Date of Birt	th y, Yea <i>r</i>)	9. Birth	place (State or Foreign
	Director		493-14-6497 Usual Residence of Decedent	1 X M 2 □ F	94 Y	rs.		Septembe	r 14,19	918 Mis	ssouri
	and show	៦	10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Maryla 28a-f	Director	Maryland Mont	gomery			nsington				1 🗌 Yes 2X🗆 No
	h the	al D	10e. Street and Number			10f. Zip Code	20005	ļ	9	en of What Cou	1
	ms 2:	Funeral	3618 Littleda	12. Was Decedent Eve			20895 Hispanic Origin? (Sp	ecify Yes or No-		Inited S	
9	s filed within 72 hours after death with the Maryland tal Hyglene. ed other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ N	11170	13. Was Decedent of If Yes, specify Cul		o Rican, etc.)		Black, White,	
003	urs aff :ural", al Exa	ted	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates. W		1 ☐ Yes 2 🕅 N					hite
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yla	d Mental d Mental marked metic ev	ျဍ		lam Reid Pea				elle Fra			0.41
Maryland 21215-0036	she h en 7 is		19a. Informant's Name/Relationship Michael Klyne Pe		196.	Mailing Address (Street	rden Stre	et. Bell	ir, chy or lo Lingha	ım, State, 21p	ington 98225
	Hea Hea ther		20a. Method of Disposition		20b. Place of	Disposition (Name of , crematory or other pi	III-1-			ation - City or T	
<u>E</u>	~ ~ ~ ~		1 🕅 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Arlingto	n National Ce	meteryNov.	8, 2012	Arlir	ngton,	Virginia
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Lice		01360	Robert A. Add 7557 Wiscons	imphrey Function	eral Home/ Bethesda,	Betheso Maryla	da-Chevy and 20814	Chase, Inc. -3501
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	omplications that caused t							Approximate Interval Between
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consquence of	art Failur M	е				
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89	ath certific ettending p I for use as	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy	3 ☐ Ectopic pregna	nncv		23	3d. Date of deli	
Вох	Attending Physician: The law requires that the death certify death. sctor: After this certificate has been signed by the ettending by the funeral director; page 2 should be detached for use a by the funeral director.	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown		5 Other (specify)				Month	Day Year
P.O.	that the dea ned by the e detached		Part II. Other significant conditions	s contributing to death bu	it not resulting in	n the underlying cause	given in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
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cor	aw rec as bee	Completed by							opsy	24b. Were autoprior to codeath?	opsy findings available completion of cause of
Re	: The law cate has							1 ☐ Yes	formed? 2 X No		2 □ No
ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Place of Death (Che		idence 6 M	(C) Other (Space	ryAssisted Living
of V	ding Phys th. After this funeral d	년: 일:	27. Manner of Death	28a. Date of injury	y 28b. T	ime of 28c. In		28d. Describe			William Indiana
on	eath. or: Aft the fur	fical	1 X Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	ation		M 1	☐ Yes 2☐ No		_		
Division of Vital Records,	after d Direct Jin by	Certificate:	4 Homicide determin			rm, street, factory, offic	e	28f. Location City or To	(Street and i wn, State)	Number or Rur	rai Route Number,
О (To the Hospital or Attend within 24 hours after death To the Funerel Director: / completely filled in by the	Medical	(Check 2 Medical Ex	Physician: To the best of r aminer: On the basis of ex	amination and/o	r investigation, in my op	inion, death occurred	I at the time, date	and place, a	and due to the c	cause(s) and manner stated.
1)	To the I within 2 To the I complet	Ž	only one) 3 Certifying N 29b. Signature and title of certifier	Nurse Practitioner: To the	best of my know	wledge, death occurred	at the time, date and nse number	place, and due to	the cause(s	s) and manner as e signed (Month	s stated.
/	F3Fŏ L)	MYN(day		D53691			ober 22	
)	•		30. Name and address of person with		eath (Item 23a) (Type, Print) Boulevard		ckville,			
/	Sta	ate	Ajay Reddy, M.D. 31. Date filed (Month, Day, Year)	37 Registra	r's Signature	park					
	Regist		UC 126	CUIZ CERMA	J B. 1	gave					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy D. Russell Month October 21, 2012 12:08 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Parkville Baltimore 8800 Walther Blvd Apt.3606 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Mar. 25, 1910 Days Hours Months Min 214-38-3253 Director Pennsylvania 1 🗆 M 2 🔀 F 102 Usual Residence of Decedent 28a-f shov is than "naturel", or items 23a or 28a-f sho the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Parkville Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd Apt.3606 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc 1 Never Married 2 Married ğ 1 ☐ Yes 2 🕅 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) 12 Baltimore County Teacher permit. Page 1 and 2 should be filed with Department of Health end Mentel Hygier Importent: If item 27 is marked other to eny Injury or other traumatic event, the eny Once. Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Deitrich Ida Mae Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence D.Wilson-sister 300 Rachel Drive Apt. 3012-Pleasant Cap, Pennsylvania 16823 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Dulaney, Valley
Memorial Gardens 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Oct.25,2012 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility and Cremation Services 8800 Harford Rosof-Parkville, Maryland 21234 3 -23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury Due to (or as a consequence of): ettending physician and I for use as the burlei-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) Day After this certificate has been signed by the funeral director, page 2 should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Afte completely filled in by the fun 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D58646 morra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard 1 thes

Registrar DHMH 17 Rev 06-2011

State

tone 31. Date filed (Month, Day, Year)

25/2

M

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34534 State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Richardson 201^{Yea} Charles October 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 220 B Williams Road Ferndale If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Min Hours 216-30-1129 1 XM 2 🗆 F Director 9/6/33 79 Marvland Usual Residence of Decedent show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits at the Maryland **Funeral Director** must be notified 28a-f 1 Tes 2 No Ferndale MD Anne Arundel 10f. Zip Code 5 10e Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event; the Medical Examiner must by once. 220 B Williams Road 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Ş 1 Never Married 2 Married Yes 2. No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (3-4 or 5+) Independent Insurance Broker Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဝ Esther Bush Victor Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Richardson Wife 220 B Williams Road Ferndale, Maryland 21061 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Baltalano remains and remains to the Name of Control of Control of the Name of Control of Con 1 Burial 2 Cremation 3 Removal from State 10/26/12 4 Donation 5 Other (Specify) Loudon Park Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Many Jew 19 Immediate Cause (Final ()13 cars Physician/ onic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical use as IF FFMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death signed by the at be detached for signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No has page 2 certificate funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\begin{center} \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) Certificate: To 2 🖭 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Investigation Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death. Director: After this filled in by within 24 hours a

To the Funeral C

completely filled the

State

Suicide

4 Homicide

29a. Certifier

(Check

6 Could not be

determined

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 10-24-2012 0004049

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

mal

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

518 5 mo ma 31. Date filed (Month, Day, 6 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34535 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 21, 2012 5:37 PM William J. Rejevich, Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Hours 203-20-2986 1 X M 2 🗆 F 84 Yrs. July 18, 1928 Pennsylvania 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Potomac 1 ☐ Yes 2 X No Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 United States 9005 Willow Valley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Technical Sales Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Runta Frank Rejevich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9005 Willow Valley Drive, Potomac, Maryland 20854 Frances G. Rejevich / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of October 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State All Souls Cemetery 2012 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 25, Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 phylate Burne M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Massive Intracerebral Hemorrhage Due to Fall disease or condition resulting in death) Due to (or as a consequence of) Atrial Fibrillation Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ર કે 10 0 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

permit. Page 1 and 2 should be filed within 72 hours after deat Department of health and Mental Hygiene. Important: If item 27 is marked other *** any injury or other trainment. Physician/ Medical **Examiner** at ending physician and I for use as the burial-tran

The law requires that the death certificate be

been signed by the a

has

this certificate

Hospital or Attending Physician: 24 hours after death.
Funeral Director, After this certifica

To the Hosp within 24 ho To the Fune completely f

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

show

the Maryland

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Director

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Completed

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ems 23a or 28a-f shor must be notified a

items death

Examiner

Examine Physician/Medical þ Completed page 2 filled in by the funeral director, Be 10 Certificate:

Medical

in the past 12 months?
1 ☐ Yes 2 ☐ No Cardiac Arrhythmia

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 11:30 AM-1:00 PM 10/21/12 Natural Accident 5 Pending work? 1 ☐ Yes 2 🔀 No Fall Investigation 6 Could not be Suicide

3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined At Home

28f. Location (Street and Number of Rural Route Number, City or Town, State) Valler o tomac

October 21, 2012

🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sigr 29d. Date signed (Month, Day, Year) 29c. License number

D0065182

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 Zenyz Sima Nourani, M.D.

State Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert, Smith Month Oct. Physician/ Y2012 0131M Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 390-34-1226 Director 1 XM 2 - F 75 June 16, 1937 Illinois Usual Residence of Dece 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director notified 1 X Yes 2 □ No Annapolis MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 21401 United States 320 Halsey Rd. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White Year or Dates. 1957-59 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government / College (1-4 or 5+) Elementary/Secondary (0-12) National Security Agcy Senior Executive 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Ferris Smith Mary Ear1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Halsey Rd., Annapolis, MD Gail Eileen Smith / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/26/2012 Beltsville, MD Name and Address of Facility app Funeral and Cremation Services 22. Name and Address of Facility Rapp Funeral and Cremation Se 933 Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Intracrania disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 38 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth ∠☐ retailes.☐ ☐ Pregnant at time of death Į, in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the at d be detached for 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an ate has t performed? Yes 2 No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License numbe 2 Oct. 24, 2012 P100554

State Registrar 30. Name and addre

of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Suite 5120, Baltimore, MD, 21201 31. Date filed (Month, Day-Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death) Soloto C Physician/ stephens 910 A M 2012 les Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Mitchellville Villa Rosa Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Numbe 7. Age (In yrs. last birthday **Funeral** Hours Director 225-24-7882 1 X M 2 D F 89 Yrs June 12, 1923 Lynchburg, VA Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State with the Maryland must be notified at Director 1 Yes 2 □ No Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 20785 1523 Belle Haven Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status rmed Forces? Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12yrs Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Eugene Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6927 Kenttown Drive Landover, MD 20785 Charles D. Stephens/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 10/27/2012 Mt. Zion Cemetery Appomattox, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Signature of Funeral Service Licensee 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ultiple 0 lomo Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear 4 Pregnant Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ena 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 🗌 Yes 2 🗎 No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending injury within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title

3800 Lottsford Vista Road Mitchellville, Md 31. Date filed (Month, Day 32. Registrar's Signature OCT 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eau

29c. License number

D6653337

29d. Date signed (Month, Day, Year)

October 23 2012

aniel M Shorter			ate of Marylan	d / Depa		Health and			_	12 3453	
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, Midd				Dealli		2. Date of Dear Month October 1		3. Time of Death	
icaloai Exami		4a. Facility Name (if not institution Meritus Medical Center	n, give street and numb	M. Short		4b. City, Town, or I. Hagerstown	ocation of Death	October 1	4c. County of Washing	of Death	
Funeral Director		5. Social Security Number 219-19-3343	6. Sex 7. 1 ✓ M 2 F	Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		7	th(MM/DD/YYYY	9. Birthplace (State or Foreign CountryMaryland	
death with the Maryland or items 23a or 28a-f show any must be notiffed at once.	9	Usual Residence of Decedent 10a. State 10b. County MD W 10e. Street and Number 13300 Hunter Hill Dri	Vashington ve, #G	10c. City,	Town or Locati		lagerstown 21742	1	0g. Citizen of Wh	10d, Inside City Limits 1 Yes 2 No nat Country?	
	by Fune			es? 2 No completed)	If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: Inpleted) 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired to the property of working life. DO NOT use retired to the property of working life.			Rican, etc.) White, etc Specify: vork done 16b. Kind of Busines		White	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Be Completed	12 17. Father's Name (First, Middle,	College (1-4 Last) David Shor			Electr	rician Construction 8.Mother's Name (First, Middle, Maiden Surname) Teresa Stevens				
MD 212. nd 2 should be alth and Menta im 27 is marke	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St Teresa L. Leizear / Mother 13300 Hunter Hill Drive, #G, Hagerstown, MD 217- 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City								n, State, Zip Code) 1742		
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Market injury or other event		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Chesapeake Crematory 10/25/2012 Beltsvil 21. Signator of Funeral Service Licensee Doroga Marshall Maryland Cremation Services, PO Box 1413 Baltimo									
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	(Morph	Do not enter the	ne mode of dying, s	such as cardiac or				
d sit	튑	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. Due to (or as a co								
execul an and al - tra	cian/Medical	d. X UNPENDED								delivery Day Year	
ecords, P.O. Bit it is a law requires that the de to has been signed by the ge 2 should be detached f	Completed by Physic	Part II. Other significant condit			sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes	an 24b. V sy p med? d	poute to the cause of death? Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 2 No	
n of Vital fing Physician: After this certi funeral director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident Invest	Hospital: 1 Inp. 28a. Date of (Month, Date of the particular of t	ay,Year) -19-12	28b. Time of In	3 DOA Chiury 28c. Injury 1 Ye	at Work?	nly one) Home 5 28d. Describe t	Residence 6	Other:	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ပြ	29a. Certifier 1 Certifying Pt	d not be	Single f my knowledge	Family e, death occum	ed at the time, date	e and place, and	or Town, S Apt G due to the caus	tate)13300 Hagersto e(s) and manner	as stated.	
Tot with: Total	Med	29b. Signature and title of certifie	and manner state	ed.		29c. License O.C.M	number	ano, valo		d (Month, Day, Year)	
Sta Registr	ite	Ana Rubio M.D., Ph. [31. Date filed (Month, Day, Year)	D. Assistant Me	•	iner 900	W. Baltimore	Street, Baltim	ore, MD 21	223		
DHMH 17 Rev 1/20 OCME 2006	_	 	0000		ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

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			1. Decedent's Name (First, Middle, Last)				2. Date of Death	201	3. Time of Death
	Physicia Medic		CHRISTINE SINCLAIR				Month October 2	Day Year 24,2012	8:40 A M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	1
أفمسيه			Holy Cross Hospital	(In the late of th	Silver	Spring If Under 24 Hrs.	8. Date of Birth		ery County irthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 1 M 2 1 TF	(In yrs. last birthday)	Months Days	Hours Min.	(Month, Day, Ye March 11	ear) C	ountry) uth Carolina
			Usual Residence of Decedent	96 Yrs.			March 11	,1710 50	
	rand r sho	후	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-	irec	DC	wasningi	on, D.C.		100	g. Citizen of What C	
	th the	Funeral Director	10e. Street and Number		2000	2	100	U.S.A	Souridy:
	ath w	nue	322 16th Street, N.E. 11. Marital Status 12. Was Decedent E	ver in U.S. 13. \	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
99	1 end 2 should be filed within 72 hours efter death with the Meryland if Heelth and Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaminer must be notified at	ক্র	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ▼	No	f Yes, specify Cuba 1 ☐ Yes 2 🌠 No		Rican, etc.)	Black, Wh Specify: B	
Maryland 21215-0036	ours cours	Completed	3 XWidowed 4 ☐ Divorced Year or Dates.	16a. Dece	dent's Usual Occupa	ation	16	6b. Kind of Busines	ss/Industry
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n D	e filed ntel Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Mai Watts	iden Surname)	
ž	should be end Ment ls marker raumatic		Weldon Chambers 19a. Informant's Name/Relationship (Type, Print)	19h Maili	na Address (Street a		al Route Number, Ci	itv or Town. State.	Zip Code)
Z	12 should be sho		James E. Sinclair/ Son				Vashingtor		
Je,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo	osition (Name of matory or other place		Date 20	0c. Location - City	or Town, State
<u><u>E</u></u>	Pege ment o ant: If ury or		4 □ Donation 5 □ Other (Specify)	Cedar Hi	11 Cemete	ry Oct.3	30,2012 St	itland,	Maryland
Baltimore,	permit. Pege Depertment Important: II any injury or once.		21. Signature of Funeral Service Licensee	al Home, Inc. d 20746					
		Г	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition		RATION				Onset and Death
	Medical Examiner		resulting in death) Due to (or as	a consequence of):					
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Ä.	the e	ysk	1 Yes 2 ANo 4 Pregnant: 9 Unknown 9 Unknown						
P.O.	that the		Part II. Other significant conditions contributing to death	out not resulting in the	underlying cause gi	ven in Part I.	1		e to the cause of death?
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≥	ding Physith. After this funeral di	<u>اة</u>	27. Manner of Death 28a. Date of inj		of 28c. Inju	ry at	lome 5 Residen 28d. Describe how		Decity)
Z Z	eth. r: Afte	icat	1 🔯 Natural 5 🗆 Pending (Month, Di	ay, Year) injury	M 1 □	Yes 2 No			
DEMENTIA 26. Place of De Other: 1							28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
Ω	To the Hospital or Atter within 24 hours efter de To the Funeral Directo completely filled in by th	Medical Certificate:	29a. Certifier (Check 2 Medical Examiner: On the basis of	examination and/or inve	stigation, in my opini	ion, death occurred	at the time, date and	l place, and due to t	he cause(s) and manner stated.
	To the H within 24 To the Formplete	Ž	only one) 3 Certifying Nurse Practitioner: To t	he best of my knowledg	e, death occurred at	the time, date and p	place, and due to the	cause(s) and mann	er as stated.
	₽≥₽ 8		235. Signature and ultravious		D6257			ctober 2	
			30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)			1 - 1 00:	010
)				orest Glen	Road Sil	Lver Spr	ing, Mary	tand 20	910
	Sta Regist	ate rar	31. Date filed (Month, Đay, Year) 32. Begist	rar's Signature					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 19, 2012 7:50 a Lillian Tomlinson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min Months Days Hours (Month, Day, Year) 413-10-2861 1 □ M 2 X F 91 Dec. 4, 1920 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🗓 No MD Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12843 Stone Eagle Rd. 21131 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Case Administrator Social Security Admin 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elbert. Sergent Harbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. Tomlinson (Son) 12843 Stone Eagle Rd., Phoenix, MD. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3X Removal from State Oak HiII Mem. Park. 10/24/12 Kingsport, TN. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Ray 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a gonsequence of that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 26. Place of Death (Check only one) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Physician/ Medical Examiner Examiner

Physician/

Medical

Examiner

Funeral

Director

show

28a-f

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or items 23a

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner I

Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

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death

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Page 1

A.M.

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Physician/Medical

Completed by

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Certificate:

29a. Certifier

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Division of Vital Records, P.O. Box 68760 director, page 2 should After this certificate has

LILLIAN

TOMLINSON,

completely filled in by the funeral e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Medical To the I within 2 To the I 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP

2300 DULANEY VALLEY ROAD

TIMONIUM 21093 MD

State Registrar 31. Date filed (MoOCT, 2°6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #25, PER ME State of Maryland / TRT Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GERTRUDE NARCISUS 1:45 PM Medical BCTOBER 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Baltimore Hourbar N/A 6. Sex 7. Age (In yrs. las If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours Director 1 🗆 M 2 🙀 F 77 May 30, 1935 Marvland 1 4 1 28a-f show Oa. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified N/A Maryland **Baltimore** 1 X Yes 2 No or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be 23a Funeral 2813 GAnley Drive USA items 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 0 ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 'natural", Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife & Mother the Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Paul Gauniel Margaret Kaiser traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or any Laura Testerman (Daughter) 2813 Ganley Drive, Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗀 Removal from State Bayview Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10/18/12 Signature of Funeral Se ice Licensee Kevin E Ecker McCully-Polyniak Funeral Home, once. 22. Name and Address of Facility 237 East Patapsco Avenue, Baltimore, Maryland 21225-1856 MO0175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMI and burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a Star bours after death.
 Funeral Director: After this certificate has been signed by the attending physicis etely filled in by the funeral director, page 2 should be detached for use as the bour Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 □ Unknown 1 Yes 2 No Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes ည 1 ► Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gortflying Nurse Frantitioner. To the best of fight will be death occurred at the late and place, and one to the cause(s) and manner as stated. (Check To the I within 2 only and 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) PHYSIC HAN D0067394 ddress of person who completed cause of death (Item 23a) (Type, Print) S. HANOVER ST, BALTIMORE 3001 - KARIKKINE 32. R strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October October Iğ. Faith Tripp 2012 7:01 A M Barbara Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1603 Elrino St. Baltimore City 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country Director 999-99-9999 Usual Residence of Dece 1 □ M 2 🏋F 62 Feb. 28,1950 North Carolina or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b Count within 72 hours efter death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1603 Elrino St. 21224 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Worker Shipping Company t. Page 1 and 2 should be filed wit tment of Health and Mental Hygle rtant: If Item 27 Is marked other jury or other traumatic event, 社 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flemke Carl Joseph Elizabeth Altman Kulczar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Alfred Tripp / Husband 1603 Elrino St., Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: It any Injury or 4 Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 10/19/2012 Bethesda, MD Signature of Funeral Ser 22. Name and Address of Facility
Rapp Funeral and Cremation Services M00382 Gist Ave.. <u>Silver Spring</u>, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the buriel-transit Physician: The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical bivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year ete has been signed by the a page 2 should be detached i 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificete has I completely filled in by the funeral director, page 2 s autopsy performed' Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{Nursing Home} \) 2 \(\text{\text{Pesidence}} \) 6 \(\text{\text{Other}} \) Other (Specify) မှု 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettifying Physician: to the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Gettifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Sets, M.D. 0 ctober, 22, 2012 D 33 407 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

DEEPAK SETH, M.D.,

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31. Date filed (Months Day Year)

1. faces

DUNDALK, MD

207 WISE AVE.

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 20b, per fh. g933 11-9-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 57 PM CMO6 2012) come /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ara Old M BALTIMORE 21132 If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oex 1 M 2 □ F Days Director 10c. C/() permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Town or Location 10d. Inside City Limits 1 □Yes 2 □No Director Stowr 10g. Citizen of What Country? 10e. Street and Number 15F Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DP NQT use retire#) dary (0-12) College (1-4or 5+) anitation ngineer d7 Be ral Route Number. Cit State, Zip Code) Baltimore. 20b. Place of Di 20a. Methed of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ho. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR **Physician** DISEASE /Medical Due to (or as a consequence of): **Examiner** DIABETES MELLITUS Sequentially list conuntoris, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, CEREBROVASCULAR ACCIDENT 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 174PERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation Natural Natural 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ATTENDING PHSYSICIPESC. License number 29d. Date signed (Month, Day, Year) 2012 DCTOBER D42723 Name and address of person who completed cause of death (Item 23a) (Type, Print) 010 COURT ROAD 5401 AVVERAHALLI RANDALLSTOWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

Hyung Chul 31. Date filed (Month, Day, Year) 26 Mercy Medical Center, 301 Saint Paul Place, Baltimore, MD 21202 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER Peggy Ann Watson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OWSON If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Director 214-30-3242 80 1 □ M 2XXF May 2, 1932 Maryland permit. Page 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelth and Mental Hyglene. Importent: If item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other treumetic event, the Mexical Exacting County and Department once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Jarrettsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 13932 Jarrettsville Pike 21131 America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ۾ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry grade completed) (Specify only highest Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATSON, ည Stewart R. Brown Catherine Marie Fendley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. Watson - Spouse 13932 Jarrettsville Pike, Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Monkton United Methodist
Church Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/12 Monkton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Charlel and Cremation Services 16924 York Road, Monkton, MD 211111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ RESPIRATORY ARDIO Medical resulting in death) Due to (or as a consequence of) Examiner NTRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ettending physician end I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The lew requires thet the death certificate be executed Physician/Medical ORONARY P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death signed by the et d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOGENIC SHOCK Division of Vital Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown peen LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗶 No 2م| 1 🔼 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 🔀 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31826 10-24-12 Ŋ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 RICHARD LINTH 31. Date filed (Month, Day, Year) State 26 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G932 10/26/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ L. WILLIAMS 1214 CHRISTINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE CLOM WELL CENTEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F 3/10/32 Year Pennsylvania 80 Director 220-30-6907 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show approximation or other traumatic event, the Medical Examiner must be approximated. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Rosedale 1 Yes 2 No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6 Clayfield Court 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married Ď 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Juanita Spencer James Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosedale, Maryland Clayfield Court Nancy A. Fox Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/27/2012 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10/20/12 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 21229 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or conshock, or heart failure. List only blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SEP TIC SULOCIK Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) C72 W Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLEN TIA STA6E 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director; After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide within 24 hours after death.

To the Funeral Director, A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DF. Deleado MD 1732717 BTIO EMGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w. JE16/130 BALTIMONE MW ERNANJO 31. Date filed (Month, Day, Year) State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ Kenia J. Walker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Prince George's Cheverly Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 1 □ M 2 🗓 F None Oct. 18, 2012 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State Director 1X Yes 2 □ No Forestville MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 USA 3715 Donnell Drive Apt. 303 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No 1 X Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None 0 None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Jetta Marie Butler Dwayne Walker Keith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurál Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or with 3715 Donnell Dr. Apt 303, Forestville, MD 20747 Jetta M. Butler/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Riverdale Crematory Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2012 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7474 Landover Road, Hyattsville, MD 20785 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ou et and Death Immediate Cause (Final - Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred

the burial-transit attending physician Box 687605 as use Il or Attending Physician: The law requires that the death after death.

Director: After this certificate has been signed by the atter ó signed by the a P.O. Division of Vital Records, page 2 s funeral director, Certificate:

28a-f show

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items death

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e 1 and 2 should be filed within 72 of Health and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Med

Maryland 21215-0036

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must be notified at

Examiner

the Medical

1 Natural	5 Pending
2 Accident	Investigation
3 Suicide	6 Could not
4 Hamioida	determine

29a. Certifier

be

28c. Injury at work? 1 🔲 Yes 2 🔲 No

		At home,	farm,	street,	factory,	office
building,	etc. (Sp	pecify)				

of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	only one)			Nurse Pra		
29b.	Signature ar	d title	of certifier		V	

examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

He best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 623

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Mopth, Day, Year)

State

MI 31. Date filed (Month, Day, Year)

Registrar

To the Hospital within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, amend #5 Per FH G931 9/05/2012 Jh State of Maryland / Department of Health and Mental Hygiene 2012 AMEND #25, PER ME G932 10/24/12 TRT Certificate of Death Reg. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 111 . Medical 4a. Facility Name_(if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Advantist H Takona 7. Age (In yrs. last birthday If Under g. Birthplace If Under 24 Hrs. 8. Date of Birth (Month, Day, 2245°56™9545 6. Sex **Funeral** Country) Months Hours Min. Director 1 M 2 □ F 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director otified 1 Yes 2 No DC 10e. Street and Number 0 10g. Citizen of What Country? must be Funeral 20020 Good items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc. þ o. 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: "natural" Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lborek Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Pemoval from State 4 ☐ Donation 5 ☐ Other (Specify) meral B. . . Licensee Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Candre VAICA MAKETOSCIETONL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-trai Due to (or as a consequence of): physician Certificate: To Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Qualiplegic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform has Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1X Yes 1 Inpatient 2 A/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner Death 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation s after death Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, by 4 Homicide determined City or Town, State) filled in within 24 hours a

To the Funeral D

completely filled i Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3542 07-25-2012 address of person who completed cause of death (Item 23a) (Type, Print) Smr. C

State Registrar 31. Date filed (Month, Day, Year)

32. Regi

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	and show	ō	10a. State 10b. County		10c. City	, Town or Loca	ation	<u> </u>			1	10d. Inside City Limits
	Maryl 28a-f	irec	4	Arundel		Baltir	nore					1 🗌 Yes 2 🛣 No
	a 23a or	Funeral Director	10e. Street and Number 7925 East End	Drive			10f. Zip Code	21226		10g. Cit	tizen of What Co USA	ountry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "neturel", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	<u>ج</u>	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.	No	lf.	as Decedent of I Yes, specify Cub	Hispanic Origin? (San, Mexican, Puer	pecify Yes or No to Rican, etc.)		14. Race - Ame Black, Whit Specify:	
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, u	eath. or: Afte the fun	ficat	1 Natural 5 ☐ Pending 2 X Accident Investigat 3 ☐ Suicide 6 ☐ Could no			injury UNK	M 1 🗆	ḱ?]Yes 2∭No	SUBJECT		•	
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	n 24 hou n 24 hou ne Funer pletely fill	Medica	Check 2 ∟ Medical Exa	hysician: To the best of miner: On the basis of e urse Practitioner: To the	xamination	and/or investig	ation, in my opini	on, death occurred	at the time, date	and place,	, and due to the	cause(s) and manner stated.
	No strict		29b. Signature and title of certifier	10			29c. Licens			29d. Dat	te signed (Mont	h, Day, Year)
	10,		30. Name and address of person who	o completed cause of de	eath (Item	23a) (Type, Pri	nt)	NZW5			0-12	-12-
	Sta		FRANCIS KHOO 31. Date filed (Month, Day, Year)), M . D . 7	601	05	LER D	RIVE	TOWSON	(, M	D 21	204
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}22,2^{Year}12 Physician/ October Kendell K. Wilson Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Middle River Examiner 4c. County of Death 1114 Burke Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 223-68-6530 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 TTN **Funeral** July 16, Year) 49 Months Days Hours VA Director 63 1 X M 2 D F Usual Residence of Deceden or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours aftar daath with tha Maryland Director Baltimore Middle River MD 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 1114 Burke Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 \(\sum \) No Black, White, et <u>چ</u> 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiana. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Truck Driver July be file and Mental Hy, in them 27 is marked other or other traumatic every Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meany injury or other. Jerrine Barbour William E. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1114 Burke Road Balto. MD 21220 Deborah S. Wilson /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Baltimore MD 10/23/12 1 Burial 2XX Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave.Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner AD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sloian end burial-transit Physician: The law raquires that the daath cartificata ba executed Due to (or as a consequence of): resulting in death) Last ed by the ettending physician datached for use as the buria Physiclan/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Year Yes 2 □ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 8 cata has baen siç ; paga 2 should t 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I complately filled in by the funeral director, pag Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge does occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) alillhan mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 V ALIKHAN, U.D. ST MAUMORD Jose Ik Cerclin: 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 06-2011

State

Registrar

740556752

South Greene street, Rm N3E09 Boltimon MD 21201

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2012

M.D

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

oseph

OCT 2 6 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34552 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician AM Ohn Ctober 2012 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center n/a If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 11/26/1939 1**X** M 2 □ F MARYLAND 216 36 6621 72 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 XNo VA HALLIEFORD Director MATHEWS 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 2196 HALLIEFORD 23068 USA ROAD Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ⊠ Yes 2 □ No
If Yes, Give 1958-62
Year or Dates: 1 Never Married 2 Married 0. 1 ☐ Yes 2X No Specify: WHITE ģ 3 XWidowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) oe filed within al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) MAINTENANCE FOREMAN BETH STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance of and Mental H Be JOHN B. WALTER SR. DELLA WALINEMI ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau MARK S. WALTER SON 3000 Paddock Road WESTON, FLORIDA 33331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/27/12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 22. Name and Address of Facility CVACH/ROSEDALE FUNERALHOME 21. Signature of Funeral Sevice Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dis shock, or heart failure. List only one cause on each line. Immediate Cause (Final t (or as a consequent of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records, 1 Tes 2 No 3 Probably 4 → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident neral Director: A 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral Completely filled 29a. Certifier Kcertifying Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Matther

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eton

Sing

OCT 2 6 2012

21215-0036

Baltimore, Maryland

Registrar's Signature

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34553 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Month Physician/ 3:52 AM Medical la Facility Name (if not institution, give street and number) CANDALLS TOWN BALTIMORE City, Town, or Location of Deat **Examiner** ARYLAND Age (In yrs. last birthday) nder 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1072471955 MD 6 Director ms 23a or 28a-f show must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State Funeral Director MD Baltimore Baltimore 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6436 Kriel Street 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status ral", or iten Examiner r Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Sandalwood 1Etementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Maintenance Technician Apartment Complex Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ Corrine Dixon James King Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t. If item 27 i or other tra 3424 W. Belvedere Ave Baltimore, MD 21215 Ella Washington / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date Mt. Zion Cemetery 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once, 10.26.2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Prvide Liu 21. Son ure John End AWIII falls Funeral Directors, P.A. 4517 Park Hights Ave Baltimore, MD 21215 23a. Part I. Enter the disease, or complications una cause shoot, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Ons t and Death Immediate Cause (Final Physicano/ disease or condition resulting in death) Medical Due to (or as a consequent **Examiner** Se wentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Pregnant at time of death 1 L tes 2 ... 9 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending Investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, pleted filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068454 10.18.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NG

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Description of Head	Department or result when the property of the maturals, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Service Licensee) 22			Brinsfie					
	1 = 10 01		Edward N. Brinsfield Jr.M000 23a. Part 1. Enter the disease, or complications that caused the deat				d Road, Le			n, MI	Approximate	
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that the death certificate be	To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnat 1 Live Birth 2 Fetter 4 Pregnant at time of 9 Unknown	al death 3 death 5 death 6 dea	Ectopic pregna Other (specify)				Mo o use contr	ibute to t	Day Year	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 19:55 PM NTOHN 2012 october Medical . Facility Name (if not institution, give street and nu City, Town, or Location of Death **Examiner** 4c. County of Death topkins 405 JOHNS Baltimore City n vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1 🗗 M 2 🗆 F Director 248-45-5082 32 SC 12/17/1979 Usual Residence of Deci 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director NY New York City 1 X Yes 2 No New York 10e. Street and Number ò 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 342 Manhattan Avenue, 10026 items ? hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married ð 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Dancer/Entertainer Entertainment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charlie Ways Angela Ashley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Ashley/mother 2338 Jenna's Way, Conyers, GA 30013 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 10/12/2012 Silver Spring, MD Signature A Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home MO1576 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) Asystol disease or condition Medical resulting in death) Examiner ension Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events larch LONS that the death certificate be executed burial-trans physician and resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 Pregnant Pregnant at time of death be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only on Hospita 1 ☐ Yes 2 No pttal: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Datelof injury
(Month, Day, Year) 28b. Time of injury
injury 28c Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 - Homicide City or Town, State, To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of gertifier 29d. Date signed (Month. Dav. Year) RES-000 Uctober 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 orleans St,

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Date filed (Month, Day, Year)

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1 1 2012

32. Registrar's Signature

12-07523 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Marta Julia Andrade State of Maryland / Department of Health and Mental Hygiene 2012 34556 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Marta Julia Andrade October 4, 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) **Funeral** 43 Months Days Hours Director None 1 M 2 X F 08/16/1969 Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmite event, the Medical Examiner must be neitlifed at once. Montgomery Gaithersburg Director 10g. Citizen of What Country 10e Street and Number 10f. Zip Code 20878 Honduras 33 Mirrasou Ln Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 No specify: Honduras nt of Health and Mental Hygiene.

tt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. 3 Widowed If Yes, Give Year Specify: 4 Divorced <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Warehouse 9th. Sales 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elva Guillermina Mejia Jose Efrain Andrade Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Fredy Erasmo Dubon Mejia/Brother</u> Gaithersburg Md. 33 Mirrasou Ln. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 10/16/12 General Cemetery Honduras 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility John T. Rhines Euneral Home 3005 12th. St. NE Washington D.C. 20017 ase, or complications that caused the evath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** alure. List only one cause on each line /Medical a. Drowning complicated by neck injury Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be exequted Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth 3 Ectopic pregnancy Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other4 Nursing Home 5 Residence 6 Other: 1 Yes ဥ

Division of Vital Records, P.O. Box 68760, After this certificate has been To the Hospital or Attending Physician: the f completely filled in by

Certification:

Medical

State Registra

27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred							
1 Natural 5 Pending	Oct 4, 2012	1312 hrs	1 Yes 2 ✔ No	Subject jumped into shallow water							
2 Accident Investigation											
3 ✓ Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, street, factor	y, office building, etc.	28f. Location (Street and Number or Rural Route Number, City							
4 Homicide determined	(Specify) Lake	or Town, State) Islandside Drive at Dockside Terrace, Montgomery V									
29a. Certifier 1 Certifying Physician:	To the best of my knowled	ge, death occurred at th	ne time, date and place, and	due to the cause(s) and manner as stated.							
one) 2 Medical Examiner: Or	Oricon tiny										
	d manner stated,	_/									
29b. Signature and title of certifier		29	9c. License number	29d. Date signed (Month, Day, Year)							
lelle	O.C.M.E. October 5, 2012										
30. Name and address of person who com	pleted cause of death (Item	23a)									
Zabiullah Ali, M.D. Assista	nt Medical Examiner	900 W. Baltimo	ore Street, Baltimore,	MD 21223							
31. Date filed (Month, Day, Year)	22. Registrar's Signatu	backet									

3 Time of Death

1417 hrs

Country) Honduras

10d. Inside City Limits 1 Yes 2 No

Approximate Interval

Between Onset and

Death

Year

Day

9. Birthplace (State or

Hispanic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/8/2012 JASPER BRASWELL, JR. 2:15 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Silver Spring 4cMontgonery 13102 Collingwood Terrace If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1/12/1934 78 245-48-9957 Director 1 ☐ M 2 ☐ F NC th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector MD Silver Spring 1 X Yes 2 ☐ No Montgamery 悥 10g, Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Funeral 20904 13102 Collingwood Terrace within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

12 Yes 2 1953-55 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use mixed) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heath Human Services College (1-20-5+) Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any Injury or other traumatic avent the Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jasper Braswell, Sr. Cherry Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Braswell/wife 13102 Collingwood Terrace, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Cheltenham Veterans 4 Donation 5 Other (Specify) 10/18/2012 Cheltenham, MD En wen Fureral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1576 246 N. Washington Street, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Alzheimers disease advanced Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and dor use as the burial-transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ed by the a 9 Unknown 9 Unknown P.O. signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Diabetes Mellitus Type II of Vital Records, 1 ☐ Yes 2 ᡮ No 3 ☐ Probably 4 ☐ Unknown cate has been significant page 2 should t Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, page Hyperlipidemic 25. Was case referred to medica 1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 1 🗌 Yes 2 DNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso Charles L. Fra 31. Date filed (Month, Day, Year) Franklin, Jr., 11223 Tockwood Drive, Silver Spring, MD 20901 State 32. Registrar's Signature 11 2012 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend #18 per FD, RegistranDOR, 10/11/12, LDB

1. Decedent's Name (First, Middle, Last) Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death Month Year **Physician** 1205 October OOSevelt 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital EASTON

If Under 1 Year | If Under 24 Hrs. Memoral EASTON TALBOT 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) (State or Foreign 5. Social Security Number Months **Funeral** Days Hours 1 M 2 □ F 239-48-1252 Usual Residence of Decedent North Carolina Director Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County items 23a or 28a-f show ner must be notified at 1 ☑Yes 2 ☐ No Directo ambridge 10f. Zip Coce 10g. Citizen of What Country? 10e. Street and Number 16/3 acum Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or iten Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 1 No 21215-0036 Black Specify: ģ 3 ☐ Widowed 4 ☐ Divorced er than "nature, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) rating ionstruction (0. Engineer 18. Molner's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be is marked Maude averly 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If Item 27 is any Injury or other trau once. anula Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Logation - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 113/12 Cambridge 10 Bethel Lemetery! 4 Donation 5 Dother (Specify) 2. Name and Address of Facility Henry Funeral Hame, P. A. 510 Washington St. Cambridge, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD. 2/6/3 lle 23a. Pakt/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Emboli Septic **Physician** disease or conditior resulting in death) /Medical Due to (or as a consequence of): Examiner noto (Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physiclan and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown been signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Naknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed: 1□ Yes 2 NO Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → 2 ER/Outpatient 3 DOA 1 Nepatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis M. DeShields, M.D. 219 S. Washington Street, Easton, MD 21601 32/ Registrar's Signature 31. Date filed (Month, Day, Year) State Dark Registrar OCT 11201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 11:00PM Barbara Bynum 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Talbot Easton Genesis HealthCare-The Pines 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Days 3-21-1928 1 ☐ M 2X F Orange, 135-22-9511 85 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21601 USA 9143 Honeysuckle Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. Completed by 1 Never Married 2 ☐ Married Spec African 1 ☐ Yes 2X No Specify 3 Divorced 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing <u> Machine Operator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pearl Dupree Wilkins Bynum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Honevsuckle Drive, Easton, MD 21601 Cheryl Jordan/Daughter 9143 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rosedale Cemetery 10-13-2012Orange, NJ 21. Signature Funeral S vice License 22. Name and Address of Facility PO Box 326 McPherson Funeral Milford. DE 19936 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line. Onset and Death DEMENTIA Immediate Cause (Final STAGE ND Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner AILURE TO THRIVE 6 mts Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the sahould be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Suursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 2 No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi 29c License number

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of fleath (Item 23a) Type, Print) 10

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Claire Porter Crenshaw 7:40 P M October 0 8. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg 407 Russell Avenue, Apt. 416 Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours 577-26-7493 Director 1 □ M 2 🔼 F 88 Oct. 7, 1924 Washington, DC i Hygiene. other then "neturel", or items 23e or 28e-f show vent, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter deeth with the Meryland Director 1 Yes 2 X No Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 JSA 407 Russell Avenue, Apt. 416 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 ☑ No ٤ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Operations Supervisor Communications permit. Page 1 and 2 should be filed wit Depertment of Heelth and Mental Hygles Importent: If Item 27 is merked other 1 any Injury or other traumetic event, the page. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen M. Mickel Walter E. Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5646 South Renn Road, Frederick, MD 21703 Debra E. Fitzgerald/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. Date 0. cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) 2012 Alexandria, VA 21. Signature of Funeral Service Licensee Francis Adress Corina Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner yrs Hyperlipidemia Sequentially list conditions, if any, leading to immediate cause. Find I had mying Cause (Disease or injury Examine Due to (or as a consequence of) Hospitel or Attending Physicien: The lew requires that the death certificate be executed 24 hours effer deeth. ettending physicien and d for use es the burial-trape Hypertension yrs that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Year signed by the et d be deteched fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown To the Hospitel or Attending Physicien: The lew require within 24 hours effer deeth.

To the Funeral Director: After this certificate hes been shooppletely filled in by the funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 AN 2 🗆 No 1 Tes 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X} \) Residence 6 \(\sum \) Other (Specify) 2 🖾 No 1 Yes |₽ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Roji Menon, MD

31. Date filed (Month, Day, Year)

10901 Connecticut Avenue, Kensington, MD 20895

son who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

0057870

109

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10/7/2012 Physician/ 2245 p MELVIN COURSEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Casey House-Montgomery Hospice Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Months Hours (Month, Day, Year) Country) Director 136-40-1568 1 XM 2 | F 64 1/30/1948 NJ Usual Residence of Decede ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 😾 Yes 2 🗆 No MD Montgamery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11215 Oak Leaf Drive, #1708 20901 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Security Guard/Alpha Sec. Elementary/Secondary (0-12) College (1-4 or 5+) Security 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Johnson Anna Coursey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11215 Oak Leaf Dr., #1708, Silver Spring, MD 20901 Cynthia White/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Crematic Corporator of Crematic Corporator of Corporator Office (Name of Crematic Corporator) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/10/2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home Dency Washington St., Rockville, MD 20850 246 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Ischemic cardiomyopathy Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ettending physician and I for use as the burial transi Physician: The law requires that the death certificate be executed Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the er Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 No 1 Yes 2 3-No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဍ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of

Geoffrey Coleman,

11

31. Date filed (Month, Day, Year)

erson who completed cause of ceath (Item 23a) (Type, Print)

D37142

1355 Piccard Drive, Suite 100, Rockville, MD 20850

10/8/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 9 Day 2012 Rufina 6:42 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20435 Kings Crest Blvd. Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 267-65-8126 Hours Director 1 M 2 24 F 71 Nov. 7, 1940 Philippines Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20435 Kings Crest Blvd. 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black White etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 If Yes. Give 1 Yes 2 K No Specify. SpecifyPacific Islander 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administration NRA injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Daniel V. San Miguel Felisa S. Santa Ana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna S. San Miguel/Sister 20435 Kings Crest Blvd., Hagerstown, MD 21742 Baltimore, Important: if item eny injury or other 20b. Place of Disposition (Name of cometery, crematory or other place)
Arlington National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Pege 1 e Department of h Dateunk 1 Burial 2 Cremation 3 Removal from State Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis Adress Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Head and Neck Cancer 6 mos Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use an executation. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ[Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 XN 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? ျှ 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. McCormack, MD

041667

11110 Medical Campus, Hagerstown, MD 21742

29d. Date signed (Month, Day, Year)

October 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) Physician/ 10/8/2012 JOYCE CAMPBELL 3:47 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20812 Scottsbury Drive Germantown Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Hours 219-48-4869 9/9/1947 Director 1 🗆 M 2 🕱 F 65 Yrs MD ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery' Germantown 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20876 20812 Scottsbury Drive iral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify. 3 Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government Admin. Secretary-NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Grace Brooks Percy Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code f Health item 27 20812 Scottsbury Drive, Germantown, MD 20876 William G. Campbell, Jr./husb. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/16/2012 Germantown, MD All Souls Cemetery 21. Signatur o Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ Senile Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial track Cause (Disease or Injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?

1 Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 XI မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes empletely filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer filer 29d. Date signed (Month, Day, Year) 10/10/2012 29c. License numbe D37142 6

State Registrar

DHMH 17 Rev 06-2011

Coleman, MD, 1355 Piccard Drive, Rockville, MD 20850

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) OCT 11 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 2012 7:30 P M Emma Harvey Cannon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester Chesapeake Woods Center Cambridge 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 1 M 2 TF 214-07-7671 7-5-1916 MD 96 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21613 101 Belvedere Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Beautician Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Storr William Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belvedere Ave. Cambridge, MD 21613 Carol Ann Daffin/daughter 101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market 10-15-2012 East New Market 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High Street Newcomb&Collins FH Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician Medical **Examiner**

attending physician and for use as the burial-trar

signed by the at

page 2

funeral director,

completely filled in by the

29b. Signature and title of certifier

patricia

OCT 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ohnsor

within 2

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

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items 23a

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er than "natur the Medical I

alth and Mental Hygiene.

27 is marked other than er traumatic event, the M.

Department of Health Important: If item 27 any injury or other tonce.

Baltimore, Maryland 21215-0036

Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

must be notified at

Funeral Director

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Completed

Be

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Medical Certificate: To Be Completed by Physician/Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition	Cerebral Vascular ac	cident	Onset and Death
resulting in death)	a. Cerebral vascular acomputer of: athleroscleretic dis	ease	louene
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		109(81/3
that initiated events resulting in death) Last	CDue to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown	23d. Dat	e of delivery nth Day Year
	contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failur		ibute to the cause of death?
		autopsy performed?	Vere autopsy findings available prior to completion of cause of leath?
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nurs	sing Home 5 Residence 6 Othe	er (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? M 1 Yes 2 \(\text{ N} \)	28d. Describe how injury occurre	
3 Suicide 6 Could not be 4 Homicide determined	29a Placa of Injuny - At home form street factors office	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,
(Check 2 Medical Exam	vsician: To the best of my knowledge, death occurred at the time, date and p niner: On the basis of examination and/or investigation, in my opinion, death occur the Practitional To the best of my browledge of all notions at the lime, date	urred at the time, date and place, and due	to the cause(s) and manner states

29c. License number

Bramble

Cambridge MC

DHMH 17 Rev 06-2011

State

Registrar

100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10³ 2ď°2 8:30 Craig Αм Pauline Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Hebron 27296 E. Lillian Street Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🗆 M 2 🗓 X F Months Days Hours Min. 1-23-1948 Maryland 218-48-7248 Director 64 Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Wicomico Hebron 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 27296 E. Lillian Street be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Completed and Mental Hygiene.
Is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ပ George Samue1 Hearne Jane Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane H. Taylor – Mother 27296 E. Lillian Street, Hebron, Maryland 21830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-11-2012 Crematory of Delmarva Delmar, Delaware 21. Signature of Furferal Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or construction shock, or heart failure. List on the construction of the c lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ne cause on each line. Immediate Cause (Final Physician/ AS CV D disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or imjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗷 No 1 Yes 3 Probably 4 Unknown cate has been significant cate page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? this certificate 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: ပု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending death. Investigation Accident 24 hours after deatl completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 047094 10/10/12 HB1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATESAN Vel 957 4

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

1 2 2012

32. Registrar's Signatur

Hermon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Z Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Cornelius Orlando Collins 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Med Ctr Salisbury Peninsula Regional 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Days Months Hours Director 213-80-2172 1 XM 2 🗆 F Yrs 10-22-1960 MD Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Princess Anne Somerset MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 USA 11330 Greenwood Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give SpeciBlack 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Somerset Co. permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella L. Collins Phillip Richardson, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 19a. Informant's Name/Relationship (Type, Print) Road Princess Anne, Gloria Collins/Sister Greenwood 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10-13-2012 Princess Anne, MD ◆ ☐ Donation 5 ☐ Other (Specify) Wesley Cem 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury. MD 21801 Signatur of Funeral Service Licensee ussell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPILEPTICUS STATUS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 3 DAYS HYPOXEMIA Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of DAYS VENTRICULAR TACHYCARDIA sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 2 104 No 1 Npatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/8/2012 MD 71743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, md, 21801 ashvir Sangwan 100 E. Corroll St. 31. Date filed (Month, Day, Year, 32. Registrar's Signature

Registrar
DHMH 17 Rev 06-2011

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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Marri 3 Widowed	4 Divorced	If Yes, Give X Year or Dates.	No 1 ☐ Yes 2 ☑ No Specify:					Black, White, etc. Specify: white					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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3		30. Name and address of person Pamela E. Southall, N	ASSISTANT Medic		,	N Baltimore	e Street F	Raltimore MD 2	1223	
	ate	31. Date filed (Month, Day Year)	32. Registrar			Daminor	o oneet, E	- WID Z	1220	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registra MEND#28a+28eperMD, 11/15/12; BW, McCoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ C Daniels Medical 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL GLEN BURNIE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral th, Day, Year) 37 Hours WASHINGTON FEB 579 46 9269 Director 1 🔀 M 2 🗆 F 75 DC Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location Ħ Director the Medical Examiner must be notified 1 XYes 2 No PASADENA ANNE ARUNDEL MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 23a Funeral USA 21122 357 HARLEM AVENUE items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1951

1 Yes 2 No to If Yes, Give 1955 14. Race - American Indian. 11 Marital Status Black, White, etc. % to 1955 1 Never Married 2 X Married "natural", or þ Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education Makrylband instate Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. other than " life. DO NOT use retired) College (1-4 or 5+) GOVERNMENT Elementary/Secondary (0-12) TECHNICIAN MAINTENANCE and Mental Hygie is marked other Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LANDONIA BROOKS ပ VANCE DANIELS pe t. Page 1 and 2 should be tment of Health and Men rtant; If item 27 is marke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 357 HARLEM AVE PASADENA MD 21122 19a. Informant's Name/Relationship (Type, Print) JOYCE DANIELS/WIFE Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date CHETTENHAM other place)
VETERANS CEM Department of H Important; If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 10/19/12 CHELTENHAM 4 Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility WATSON FH 3435 14th ST NW WASH DC 20010 CC0527 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine B Cause (Disease or injury that initiated events resulting in death) Last and Due to d as a consequence of attending physician of for use as the burial the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? certificate has page 2 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes this 28a. Date of injury (Month, Day,) 28c. Injury at Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: within 24 hours after death.

To the Funeral Director: After 5 Pending work 1 Natural 1 Yes 2 🗌 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, ejc/(Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) Paradena. Duiler 24 RI. A Mag @ Viine

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Dashiell Charles Robert 0030 AM 2012 Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death RIGIONAL MEDICAL 304 56410 HICOMICO Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 215-12-6428 Director 1 X M 2 | F Yrs. 88 11/25/1923 Delaware th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 🗌 Yes 2 🔣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 209 Creekside Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Arm Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ۵ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Divorced Completed White Army 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Certified Property Manager Property Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o ည Lula Wilkinson Charles Myron Dashiell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 209 Creekside Dr., Salisbury, MD 21804 Julia Lee Dashiell/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If it
any injury or of 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 10/13/2012 Salisbury, MD 21. Signature of Funeral Service License ²², Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of near failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Preumona Astiam Medical resulting in death) Due to (or as a consequence of): Examiner Fractures Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month 5 Other (specify) Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s this certificate has autopsy To the Hospital or Attending Physiclan: The Is within 24 hours after death.
To the Funeral Director, After this certificate h completely filled in by the funeral director, page 2 N 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ပ္ Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Stepped in hole 12 2012 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 1100 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Inspection 10448 Charles Sostan Rd Home Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 29c. License number 450447 HOO 56197 10/10/12 of person who completed cause of death (Item 23a) (Type, Print) UIVE CHRISTOPHER SNYDER 100 EAST CARROW STREET, SAUS BURY 31. Date filed (Month State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monti 10 12 2012 8:15 Susan B. Fisher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's 27815 Woodburn Hill Road **Mechanicsville** Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth **Funeral** Months (Month, Day, Year) Director 213-49-9272 1 M 2X F 32 Maryland Usual Residence of Decedent 10/03/1980 an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No Mechanics ville St. Mary's Maryland Oe. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20659 USA 27815 Woodburn Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 's any injury or other traumatic event, the Meany injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hannah S. Byler Israel S. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27815 Woodburn Hill Road Mechanicsville, MD 20659 Israel S. Fisher/ Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fisher's 10/15/2012 Mechanicsville, MD 21. Signature of Fune 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home,
41590 Fenwick Street Leonardtown, MD 0 David Goff edications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the di Approximate Interval Between shock, or heart fail Immediate Cause (Final disease or condition Onset and Death Congenital Heart Disease Years Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or in that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a
9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N this certificate has death? 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and D14285 October 15, 2012

State Registrar

CT 16 2012 Sema S. Sack

32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

MD

II,

William D. Boyd,
31. Date filed (Month, Day, Year)

25365 Point Lookout Road Leonardtown, MD

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 2012 5:45PM^M Anthony Francis Galano October 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill of Bethesda Nursing and Rehab Montgomery Bethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Min (Month, Day, Year) 132-16-0946 1 🛛 M 2 🗆 F 87 Yrs 04/23/1925 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? USA 3005 South Leisure World Blvd.APT#412 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Engineering Broadcast Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emanuel Galano Jeanne Maresca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 South Leisure World Blvd. APT# 412 Spring, 20906 MD Catherine T. Galano / Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Arlington National Cem 01/17/2013 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fun Al Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ONGESTIVE HEART FAILURE Immediate Cause (Final Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery

Ph, ician/ Medical **Examiner** Examiner The law requires that the death certificate be executed and burial-tran Division of Vital Records, P.O. Box 68760

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certificate has

or Attending Physician: eral Director: After this certific filled in by the funeral director,

Physician/

Medical

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3altimore, Maryland 21215-0036

Completed by Physician/Medical Be Certificate: To

in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Month Day Year	
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in		co use contribute to the cause of death?	
		24a. Was an autopsy performed 1 🗌 Yes 2		
25. Was case referred to medical	26. Place of Death (Check only one)			
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Volume 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 28c. Injury at work? 1 \(\text{Yes} \)	28d. Describe how in	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)	
(Check 2 Medical Examin	cian: To the best of my knowledge, death occurred at the time, dater: On the basis of examination and/or investigation, in my opinion, depractitioner: To the best of my knowledge, death occurred at the time.	ath occurred at the time, date and pla	ace, and due to the cause(s) and manner states	

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29d. Date signed (Month, Day, Year)

10/3/12

State Registrar

24 hours a Hospital

Medical

29b. Signature and title of certifier

OCT

31. Date filed (Month, Day,

Drive Registrar's Signatu 15

some, MY D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of M	1aryland	/ Departm			Menta		jiene Reg. No. 2	112	34573
	-		Registrar 1. Decedent's Name (First, Middle)	le, Last)		Ochano	210 01 2	704111		of Dea	th	V	3. Time of Death
	Physicia Medic	al		Gertrude	Guy	7			Oct	obe	r 10, 2	2012	10:45P M
	Examin	er	4a. Facility Name (if not institution 26565 Laure1			4b. C		Location of Dear			4c. Count	y of Death Ma	
Rs.	Funeral		5. Social Security Number		ge (In yrs. las	t birthday) If Ur Mont	der 1 Year	If Under 24 Hrs Hours Min	8. Date	of Birth	1	9. Birth	nplace (State or Foreign ntry)
ż	Director		217-34-0520	1 □ M 2 🗷 F	74		Days	Hours Will	10/1			1	yland
	and show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location			,				10d. Inside City Limits
	Maryla 28a-f otifiec	Director		. Mary's				csville					1 🗌 Yes 2 🔀 No
	ith the		10e. Street and Number	Court Court		(10f.	Zip Code	0659			10g. Citizen of	What Cou	untry?
	eath w tems?	Funeral	26565 Laure1 (12. Was Decedent Armed Forces		13. Was De	cedent of Hi	ispanic Origin? (S in, Mexican, Puer	Specify Yes	or No-		ce - Amer	ican Indian,
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than "natural", sy the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Ma 3 🏝 Widowed 4 ☐ Divorce	arried 1 Tyes 2 XX			s 2 X No		to riidari, e	,	Specif	ick, White	ite
8	hours natura ical E	Completed	15. Decede	ent's Education		16a. Decedent's l					16b. Kind of	Business/l	ndustry
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/lan	should be filed v n and Mental Hyg 7 is marked othe raumatic event,	욘	John David	Stone				Luc	i11e (Go1d	sborou	gh	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene, them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations Donna Faye Kn		. 1	19b. Mailing Add							Code) 20636
	and 2 s Health Item 27 other tra		20a. Method of Disposition		20b. Pla	ace of Disposition	Name of		Date		20c. Location		
m _o			1 🛣 Burial 2 □ Cremation 4 □ Donation 5 □ Other		ie	metery, crematory			16/20	12	Holly	wood,	, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21 Sin Fur Furieral Serve	Hardi	ner	22. Nam Ma 41.	and Address Tingl 590 Fe	ss of Facility ey-Gard nwick S			ral Ho	ne, F	20650
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Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mojetely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ੴNo 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 🗀 Fetal t at time of de	death 3 Ecto	pic pregnand r (specify) _	су				ate of del	ivery Day Year
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al R	rsician: The law is certificate has but director, page 2 s	Be Co	25. Was case referred to medica examiner?	al	_ ==		26. P	lace of Death (Ch			2 2 No	1 LJ Yes	2 🗌 No
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Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certificate:	3 Suicide 6 Coul	ld not be 28e. Place of I	njury - At hor etc. (Specify)	me, farm, street, fa	ctory, office				Street and Num in, State)	ber or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check 2 Medica	Ing Physician: To the best I Examiner: On the basis of Ing Nurse Practitioner: To	f examination	and/or investigatio	n, in my opini	ion, death occurre	d at the time	e, date a	and place, and o	due to the	cause(s) and manner stated.
	To the vithin To the comp	2	29b. Signature and title of certif				29c. Licens	se number			29d. Date sign	ned (Monti	n, Day, Year)
			Mana	Kussell		20.15	RO	6335T	/		10/1	1/12	
	•		30. Name and address of perso	on who completed cause of 1 41680 Miss			Leona	rdtown.	Md 20	0650			
	Sta Registr			1 6 2012 32. Regis									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0700 M 61vans Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Baltimore and (0) timore 8. Date of Rirth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Hours 6-20-1936 76 222-22-6319 1 ₹ M 2 □ F Director Delaware 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Delaware Sussex Seaford 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 10379 Airport Road 19973 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Poultry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental h Charles Givens Margaret Givens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant; If item 27 is Shirley Givens (Wife) 10379 Airport Road Seaford, Delaware 19973 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date cemetery, crematory or other pla Laurel Hill Cem. Important; If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 10-8-2012 Laurel, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 700 West Street Signature of Funeral Service Licensee 22. Name and Address of Facility Holly Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Short Damugar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enytician. Medical disease or condition resulting in death) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran and that initiated events Due to (or as a consequence resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 performe 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 2 € or Attending Physician: 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Hospital 2 No ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne eath s after death. 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniurv 1 Natural 5 Pending Accident Investigation filled in by the Sulcide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) medical Contr

State Registrar JIM E

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Scott Arthur Good	1	- For State	tate of Maryl		artment o		and I	Menta	ΙНу		g. No.	201	2	34575
Physicia	n/	Registrar 1. Decedent's Name (First, Midd	le,Last)							Date of Deat	h Dav	Year		e of Death
Medical Examin		SCOTT 4a. Facility Name (if not institution	Α.		GOODING	4b. City, Tow		action of D		October 7,	2012	unty of Deat		10 hrs
		Atlantic General Hos		umber)		Berlin	n, or Loc	Cation of D	reau i			cester		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under 2	$\overline{}$	8. Date of Birt	h(MM/DD/\	YYYY) 9. Bir Forei	thplace	(State or
Director		215-41-4379	1XM 2F		18 Yrs	Months .	Days	Hours	Min.	FEB. 2	5, 19	94 6	untry)M	IARYLAND
<u> </u>		Usual Residence of Decedent 10a. State 10b. County		I10c Cit	y, Town or Local	ion							10d. Ir	nside City Limits
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Box 68760 te death certificate be the attending physical tree the attending physical for use as the bused for use	Physician/M	3b. Was decedent pregnant in to past 12 months?	I CIVE	birth nant at time of c	laath	etal death ther (Specify		Ectopic pr	egnand	У	Mor	nth	Day	Year
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Division of Vital Records, P.O. Box 68766 ours after death certificate ours after death. Freal Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the b	D P	Part II. Other significant condi			resulting in the	underlying ca	iuse give	en in Part I						use of death? 4 🗹 Unknown
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	-	30. Name and address of perso	n who completed ca	use of déath (Ite	m 23e)									
		Zabiullah Ali, M.D.	Assistant Med			3altim ore	Street	, Baltîm	ore, N	/ID 21223				
Sta	. 1. 7.	31. Date filed (Month, Day, Year	2012	Registrar's Signa	ture Loan	La S								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time o 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oc**t**ober 10°; 2012° 5:00 AM M Herbert Gibson, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Examiner County of Death Frederick Northampton Manor Health Care Ctr. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 439-28-9864 85 Director 1 🛛 M 2 🗆 F Yrs Feb. 11 1927 Louisiana Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5554 Rivendell Place 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Roofer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Andrew Gibson Gladys Belle Shivley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Gibson/ Son 7033 Allington Manor Circle E.. Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/18/2012 Flintstone, Maryland Rocky Gap Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Reeney and Basilord PA Funeral Home 106 East Church St., Frederick, MD M01646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MON LINS Immediate Cause (Final Prostate Cancer Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed lause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the deal within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 1 ∐ Yes 2 L g ☐ Unknown g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 🛂 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D 0062223 October 11, 2012 of person who completed cause of death (Item 23a) (Type, Print) 196 Thomas Johnson Dr., Frederick, MD 21702 Praveen Bolarum, M.D.,

State Registrar 31. Date filed (Month Pay)

26

32. F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 34577 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 2012 Florence Gwyndola Hill 14 6:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 13944 Poplar Hill Road Waldorf Charles Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min (Month, Day, Year) Hours **Director** 215-36-3234 73 Yrs. 12/17/1938 Maryland Usual Residence of Deced or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director Charles Waldorf 1 Yes 2 X No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be Funeral 20601 USA 13944 Poplar Hill Road items ; within 72 hours after death Was Deceue... Armed Forces? Ves 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ian "natural", or itei Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 ₺ Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) er than the Me al Hygiene.

Jd other the Elementary/Secondary (0-12) College (1-4 or 5+) **U.S.** Government Administrator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental F 27 is marked or r traumatic ever ဂ္ Myrtle Virginia Knott Leonard Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great 21345 Oakley Road Avenue, MD 20609 Melissa Friess-Bailey/ Niece : If item 2 Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State ĕ 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State Department o Important: If any injury or 4 Donation 5 Other (Specify) Charles Memorial Grds 10/18/2012 Leonardtown, MD Signature of Foural Service 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home. P.A.
41590 Fenwick Street Leonardtown, MD 20650 David Goff Part 1. Enter the shock, or heart mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onset and Death Immediate Cause (Filed Ph i i i n Pulmonary Hypertension disease or condition yrs Medical resulting in death) Examiner Arteriosclerotic Cardiovascular Disease years Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed and the burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? After this certificate 1 Yes 2 No ☐ Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work s after death. 1 Yes 2 No the 1 Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18545 October 15, 2012 son who completed cause of death (Item 23a) (Type, Print) Phillfip//Wisotsky MD 12070 Old Line Centre Suite 207 Waldorf, MD 20602 State 1 6 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last,)		imouto	OI Boatii		2. Date of Deat	leg. No. th		3. Time of Death			
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	Funeral		5. Social Security Number 6, Sec				Year If Unde		8. Date of Birth		9. Birthp	place (State or Foreign			
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9	or its	by F	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No			Cuban, Mexic		Rican, etc.)		ck, White,				
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DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Diane Yvonne Height October :41 a.m. Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Marv's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Months 1 L M 2 X F Hours 04/13/1968 Vrs **Director** 215-70-9340 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tyes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45930 Indian Way, Apt. $_{1123}$ 20653 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner . Was Decedent Ever Armed Forces2 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "naturaf", Completed 3 Widowed 4 Divorced Black other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Corrections Officer Detention Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Anthony Berry Delores Edith Clinton 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 si Department of Health an. Important: If item 27 is n. any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Height, Jr./Husband 8436 Pine Blvd, Lusby, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter_Claver Cem. 10/22/2012 St. Inigoes, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. The Sepico icensetwasa Kathleen Santivasci M00872 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ng physician and as the burial-transit that initiated events resulting in death) Last Physician/Medical ASTO Box 68760 signed by the attending IF FEMALE: nse s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, tronsplant 2. No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has page 2 performed? Yes 2 No death? 2 🗌 No 1 🗌 Yes ivision of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending within 24 hours after death. To the Funeral Director: After Natural Accident (Month, Day, Year) 5 Pending 1 Tes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hollywood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

RMI

State

Registrar

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24035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10/09/2012 Ergelio Ruano Hernandez 13:46 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Hilchrist Hospice Care Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 0270571956 Director 115-74-9464 1 XM 2 □ F 56 Guatemala ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City, Town or Location with the Marylend 10d. Inside City Limits Director 1 X Yes 2 No MdHoward Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9533 Kilimanjaro Rd. 21045 Guatemala 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married Page 1 end 2 should be filed within 72 hours after of ment of Health and Mental Hyglene. ent: If Itsm 27 is merked other than "natural", or 1 Yes 2 No If Yes, Give altimore, Maryland 21215-0036 1 √ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Guatemala Hispanic Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9th Horse Walker of Heaith and Mentai Hygiel Itsm 27 is merked other rother traumetic event, # Racecourse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bernabe Ruano Margarita Hernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emilda Ruano/Daughter 9533 Kilimanjaro Rd. Columbia, Md. 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Depertment of Indoortant: If its any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) General Cemetery 10/19/12 Guatemala 21. Sonature Funeral Service Lice 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th. St. NE Washington D.C. 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) astrice Medical Due V (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ending physician and r use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Li yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending Work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2012 8303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65701 N. harles ST Touson my CHARLES MA 31. Date filed (Month, Day, Year) Registrar's Signature State 11 2012 OCT Registrar

12-07900 Da

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avid M. Hayes		1- For State Registrar	State of Marylan		artment of <i>rtificate of</i>		d Mental		eg. No. 20	112 3458
Physici Jedical Exami										3. Time of Death 1400 hrs
		4a. Facility Name (if not ins	stitution, give street and numb	er)	1	b. City, Town, or I	Location of De		4c. County of	Death
Funeral		13301 Southwood 5. Social Security Number		Age (In yrs. I	ast birthday)	Rockville If Under 1 Year	If Under 24	rs. 8. Date of Bir	Montgom	9. Birthplace (State or
Director		212-64-7939	1 M 2 F	57	Yrs	Months Days		lin		Foreign Country) MI)
any.		Usual Residence of Deceder 10a. State 10b. Co		10c. City,	Town or Locati	on				10d. Inside City Limits
	ō	MD 1	Montgomery		Rockv	ille				1 Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 13301 South	wood Drive			10f. Zip Code 20850		1	0g. Citizen of Wha	it Country?
Baltimore, MD 21215-0036 germit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiewith 1 flow 21 and Mental Hygiewith and "natural", or items 22 or 28 a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Decede			s Decedent of Hisp		Specify Yes or No	- 14. Race -	American Indian, Black,
er death	Funeral		Married Armed Force	es? 2 X No		es, specify Cuban,		rto Rican, etc.)	White,	etc. White
ours aftu atural"	d by	3 Widowed 4 15. Decedent's Education	Divorced If Yes, Give Year or Dates: (Specify only highest grade of	completed)	16a. Deceden	Yes 2 No	on (Give kind o		Specify: 16b. Kind of Bus	
36 in 72 ho han "n	Completed	Elementary/Secondary (0-12) College (1-4 o	or 5+)		ost of working life.	DO NOT use r	etired)	Real Es	t o to
5-00; led with tygiene other t	Com	17. Father's Name (First, M	liddle, Last)		Surve		8.Mother's Na	me (First, Middle, I		tate
2121 Id be fil Mental I	o Be	Martin Ricl	•		19h Mailing	Address /Stroot		n Joyce	Weller nber, City or Town,	State 7's Code)
MD 2 shot the and 1 and 1 is 1	-	Sara Saionta	z Hayes/Wife						-	, MD 21136
Baltimore, MD 21215-0036 Openit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiers (important: If them 7? is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition 1 X Burial 2 Cren	mation 3 Removal from	State	crematory or oth	tion (Name of cem er place)		Oct. 23,		City or Town, State
altim nit. Pay sartment sortant		4 Donation 5 Oth 21. Signature of Funeral Se	ervice Licensee		22. N	aven Cem	of Facility	2012		Spring, MD
		James	se, or complications that caus	عد	Fra 500	ncis J. (Univers	Collins ity Blv	Funeral	Home In lver Spr	c. ing.MD 20901
Physician Medical		failure. List only one o	cause on each line.							t Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final dis or condition resulting in dea				ated by A	TCOUOT	Intoxica	Elon	
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying C.	Due to (or as a cor	nsequence of	F):		-			
- 12	Examiner	(Disease or injury that initial events resulting in death)	ated C	nsequence of	<u> </u>			18	<u>.</u>	
Sox 68760, death certificate he executed to attending physician and for use as the burial - transh	edical E	X UNPENDED	dAMENDED 23	a.27.2	28a-f.pe	r me,g93	3 11-1	4-12 sm		
760, cate he exc physician the burial -		IF FEMALE:	23c. If yes, outc	come of pregr					23d. Date of d	elivery
Sox 6876 leath certificate e attending phy for use as the l	ician	23b. Was decedent pregnan past 12 months?	4 Pregnant	at time of de		aldeath 3 ∟ er (S <i>pecify)</i>	Ectopic preg	nancy	Month	Day Year
2	Physician/N	1 Yes 2 No 9 Part II. Other significant co	Unknown 9 Unknown				ven in Part I	23e Did to	hacco use contribu	ute to the cause of death?
ires that the signed by the detache	Š									Probably 4 Unknown
ords, sw requir as been s 2 should	Completed	-						24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of
Division of Vital Records, and Attanding Physician: The law requires after death. al Director: After this certificate has been sed in by the funeral director, page 2 should		25. Was case referred to me				00.01			med? de 2 ✓ No 1	ath? Yes 2 No
Vital Inysician:	To Be	examiner?	Hospital: 4 Long	itient 2	ER/Outpatient		of Death (Checother)		Residence 6	Other: Scene
n of Viding Physic		27. Manner of Death 1 Natural 5	28a. Date of In (Month, Date)	njury y,Year)	28b. Time of In		at Work?		now injury occurred	d alcohol
r Atten r Atten her deatl irector: n by the	Certification:	2 X Accident 3 Suicide 6	Investigation Id 10-		fd 1:50 ome, farm, stree	pm '''		28f. Location (S	Street and Number	or Rural Route Number, City
Div the Hospital or hin 24 hours afte the Funeral Dir apletely filled in	8	4 Homicide	determined (Specify)		idence					outhwood Dr.
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: completely filled in by the ft	Medical	(Check only	ing Physician: To the best of i Examiner: Dn the basis of examiner state	xamination ar						
To with To com	\$	29b. Signature and title of c		<u>u.</u>		29c. License		_		(Month, Day, Year)
		30. Name and address of no	erson who completed cause o	f death (Item	23a)	O.C.N	l.E.		October 19,	2012
		Donna M. Vincent			niner 900		Street, Balt	imore, MD 21	223	
St Regist		31. Date filed (Month, Day,)		rar's Signatu	re park	D.				

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month eneva Hollar Oà 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Autumn Assisted Living Washing If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Day / 1928 1 - M 2 X F Hours Country) Director 228-28-6543 84 WV Usual Residence of Deceden or 28a-f shov 10a. State 10b County 10c. City, Town or Location be notified at 10d. Inside City Limits Director Knoxville 1 Yes 2 No MD Washington Yarrowsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2 should be filed within 72 hours after death with th and Mental Hygiene. 27 is marked other than "natural", or items 23: traumatic event, the Medical Examiner must I 19604 Yarrowsburg Rd 21758 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify. 3√ Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest Elementary/Seconday (0-12) College (1-4 or 5+) Bottling Company Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Boswell Ervie Hinkle permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Mullenix, Niece 19604 Yarrowsburg Rd Knoxville MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Hill Cemetery 10/12/2012 Berryville, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility - VARE Howe John T Williams Funeral Home, Brunswick MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysiciani Dementia Medical Due to (or as a consequence of) Examiner mestive Heart Failure Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last cirrn Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) ASSISTER! 2 🔼 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Tes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Z Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) R128088 KUTEYM SMUTH CRNP 10/09/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21740 1126 Opal Kate M. Smith 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Columbus deTellious Jude, Sr. 2012 3:44P 15, October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 23348 Nicholson Street Hollywood If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours Days Min. (Month, Day, Year) 410-26-2288 **Director** 1 X M 2 D F 89 Yrs. 08/15/1923 Tennessee Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 X No Hollywood Maryland St. Mary's 10f. Zip Code 0 10e, Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 20636 USA 23348 Nicholson Street items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Forces?
Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. or þ 1 Never Married 2 Married Yes filed within 72 hours after Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed American Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the United States Army 3 Chief Warrant Officer 4 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 is marked of traumatic ever မ Page 1 and 2 should be Mattie Lee Burney Clarence James Jude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Marie Gardner Jude/ Wife 23348 Nicholson Street Hollywood, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mattingley-Gardiner
Funeral Home, PA Crematory

10/17/2012 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD 22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

41590 Fenwick Street Leonardtown, MD 20650 jara 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or Injury that initiated events resulting in death) Last tran and Due to (or as a consequence of): burial-t attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 be Division of Vital Records, 1 Yes 2 No 3 Probably 4 SUnknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 this certificate 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Daughter's funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify Home 1 Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 I DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

Registrar DHMH 17 Rev 06-2011

State

NA

29b. Signature and title of certifier

30. Name and address of per

31. Date filed (Month, Day,

Jennifer Schmidt, MD

OCT

8 1

cause of death (Item 23a) (Type, Print)

29c. License number

M0055751

40900 Mechants Lane Suite 205 Leonardtown, MD

29d. Date signed (Month, Day, Year)

10/16/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Elizabeth Ann Knight October 3:37 a.mM. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days 08/22/1939 Washington, DC 73 217-36-6483 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland St. Mary's Lexington Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20777 Poplar Ridge Road 20653 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 School Secretary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Christopher Robertson Lillian Bean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20777 Poplar Ridge Road, Lexington Park, MD 20653 <u>George A. Knight, Sr./Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem 10/19/2012 Leonardtown, MD Santivasci M. Kathleen Santivasci M. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 M00872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ardiac armythmia disease or condition resulting in death) Due to (or as a consequence of) Ispapea Due to (or as a consequence of) Due to (or as a consequence of)

Physician) Medical Examiner

attending physician and for use as the burial-transit

been signed by the s should be detached

page 2 should

After this certificate has

within 24 hours after death

To the Funeral Director: ,
completed filled in by the

Medical

within 24 hours a

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

ö

r than "natural", or items 23a o the Medical Examiner must be

Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items

of Health and Mental Hyg item 27 is marked othe other traumatic event,

ō Department of Important: If any injury or

Baltimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

Be

2

with the Maryland

Examine Physician/Medical Completed by Be မ Certificate:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

IF FEMALE:

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month Dav

23e. Did tobacco use contribute to the cause of death?

g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

g Unknown

24a. Was an performed

26. Place of Death (Check only one)

Yes 2 N

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Vear

25.	Was case referred examiner? 1 Yes 2		F
27.	Manne of Death		
	1 Matural	5 Pending	
	2 Accident	Investigation	n
	3 Suicide	6 Could not b	е
	4 Homicide	determined	

1 Inpatient 2 28a. Date of injury (Month, Day, Year)

ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one)

29d. Date signed (Month, Day, Year)

eted c

Hospital

address of person who com se of death (Item 23a) (Type, Print) DAMA Po Box JAMES m.D

6

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Brenda Kelly Joyce 3:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Peninsula Regional Medical Center Wicomico 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day, Year) Director 218-40-5240 1 M 2 X F 69 08/16/1943 Maryland permit. Page 1 and 2 should be filad within 72 hours efter daath with the Maryland Dapartment of Haelth end Mantal Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventirer must be notified at ODGs. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico 1 X Yes 2 No Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 418 Decatur Ave. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Certified Nursing Assistant</u> Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rodney Harris Anna B. Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Ann Davis/Daughter 2308 Abbott Dr., Salisbury, MD 21804 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Springhill Memory Gardens 10/12/2012 Hebron, MD Signature of Funeral Service Licensee 22 Name and Address of Facility, Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Chompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death COPD Physician/ stage disease or condition resulting in death) End Medical Due to (or as a consequence of): Examiner MI Non 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the daeth certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the Increating inector, page 2 should be detached for use as the burlai-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 ☐ Yes 2 No Certificate: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide iniury 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) africe MD 73705 10-09-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY MO CARROL furi 100 € VSha 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State

DHMH 17 Rev 06-2011

Registrar

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10/07/2012 8:55 P M Physician/ ALICE ELIZABETH LOWE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Montgomery Village Montgomery Village Nursing and Rehab 8. Date of Birth (Month, Day, Year) 05/18/1916 g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. W Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🔀 270-14-0410 Director Isual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State **Funeral Director** Medical Examiner must be notified at 1 X Yes 2 ☐ No Montgomery Village MD Montgamery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 USA 20886 **23a** 8230 Gallery Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 11. Marital Status Black, White, etc. 1 Never Married 2 Married 0 Completed by 1 Yes 2 X No Specify: Specify: Black Maryland 21215-0036 3 XWidowed 4 Divorced "natural", 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Detroit Race Course College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Maggie Twitty မှ 1 and 2 should be fi f Health and Mental item 27 is marked Ben Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 20020 Frederick Road, #22, Germantown, MD 20876 Therian Blair/granddaughter Department of Health Important: If item 27 any injury or other th 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 Bunal 2 XCremation 3 Removal from State 10-10-2012 Hanover, MD Cremation Center MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signatur uneral Service Li 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death coronary artery disease Immediate Cause (Final disease or condition resulting in death) Physician/ Due to (or as a consequence of): Medical Examiner pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine hypertension Cause (Disease or liniury the death certificate be executed that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burletings. Due to (or as a consequence of) Physician/Medical hypothyroidism Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Day in the past 12 months? 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires that Be Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an aphasia autopsy performed? Yes 2 death? page 2 s Yes r this certificate haral director, page 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2X No ၉ 28d. Describe how injury occurred 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death
Natural funeral within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral Certificate: 1 ☐ Yes 2 ☐ No 5 Pending Investigation ☐ Accident☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number Santino 29b. Signature and title of certifier October 10, 2012 DL11162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, 19129 Doctor Drive, Germantown, MD 20874 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 2012 Year Maria ам Langer 7:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 5622 Alta Vista Road Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) 384-32-4303 79 Director 1 M 2 A F Yrs July 12, 1933 Usual Residence of Decedent 28a-f show filed within 72 hours after deeth with the Marylend al Hyglene. d other than "natural", or Items 23a or 28a-f showert, the Marilea Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 X No Montgomery Bethesda ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5622 Alta Vista Road 20817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ۾ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Concierge Hospitality Be permit. Page 1 and 2 should be filed.
Depertment of Health and Mental Hy
Important: If item 27 is merked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Svend Sogaard Helen M. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Langer/Husband 5622 Alta Vista Road, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 13, 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2012 Alexandria, VA 21. Signatule of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 wes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 58 mos Immediate Cause (Final Pnysician/ Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 58 mos Uterine Cancer Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial transit. nding physicien end use as the bunal transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🖾 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 2 🔯 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 🗌 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 /A-0101235 2012 use of death (Item 23a) (Type, Print) (WRNNMC) 30. Name and address of person who completed ca Mich Stany, MD 8901 Wisconsin Ave., Bethesda, MD 20899 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar 11

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:30 am Marlow-Bennett Karen Elizabeth October_ 16, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 24894 Ivy Lane St. Mary's Hollywood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 212-68-4642 **Director** 1 🗆 M 2 🕱 F Yrs 56 Usual Residence of Decedent 04/10/1956 Maryland show 10a. State with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a 1 Yes 2 X No Maryland St. Mary's Hollywood 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? ms 23a or Funeral 24894 Ivy Lane 20636 USA items? within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or itel Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 XNo Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " ent, the Med Elementary/Secondary (0-12) College (1-4 or 5+) **5** 12 Public School School Teacher ed other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, t. Page 1 and 2 should be filed treent of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic even 2 Gracia Alice Cochran William Haworth Marlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Charles Richard Bennet/Husband 24894 Ivy Lane Hollywood, MD 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State mattingley—Gardiner (Mattingley—Gardiner Funeral Home, P.A. Crematory 10/17/2012 Leonardtown, MD ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) gradure of Funeral Service 22. Name and Address of Eacility
Mattingley-Gardiner Funeral Home,
41590 Fenwick Street Leonardtown, MD chael Jardener 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ec disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of, il any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events igned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Were autopsy findings available prior to completion of cause of has autopsy perform death? After this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending work' 2 🗌 No the 1 Investigation 6 Could not be after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital o within 24 hours af To the Funeral Di ympletely 0

State Registrar 29a. Certifier

(Check

30. Name and addre

Jennifer 31. Date filed (Month. Da

29b. Signature and title of certifier

Schmidt, MD

18

ed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

40900 Mechants Lane Suite 205 Leonardtown, MD

20650

Saida Iiliana Soto 12-07599 Ples

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nk Unk	State of Maryland / Department		lygiene	0 01 = 0							
	1- For State Certificate of Death Reg. No. 2										
Physician/ fledical Examiner	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year October 7, 2012	3. Time of Death 0559 hrs							
redical Examiner	Saida Liliana Soto Moya 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl									
	I-95 @ Route 175	Jessup	Howard								
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last birthday)) If Under 1 Year If Under 24Hrs									
Director	694-09-0775 1 M 2xF 31	Yrs. Months Days Hours Mir	8/24/1981 Fore	_{ountry)} Bolivia							
	Usual Residence of Decedent										
w ану	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits							
Maryland 28a-f show 1 at once. 9ctor	VA Falls (1 X Yes 2 No							
th the Maryland 23a or 23a-f sho notified at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	untry?							
th the	7324 Parkwood Ct Apt 302	22042	Bolivia								
or items 23 must be no Funeral	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		rican Indian, Black,							
rerde ", ori	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	X Yes 2 No specifyBol	ivian Specify: W	hite							
ours aft.	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of	work done 16b. Kind of Business								
5 72 hc	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use ret	ired)								
5-0036 led within 72 hours a Hygiene. to ther than "natural the Medical Examination Completed by		aning	domest	ic							
15-(filed of Hyging of the hitte	17. Father's Name (First, Middle, Last) Hermogeno Soto		e (First, Middle, Maiden Surname)								
ID 21215-003 2 should be filed within and Mental Hygiene. 77 is marked other th matic event, the Medianatic event, the Medianatic Page 170 Be Comp	19a. Informant's Name/Relationship (Type, Print) hrothor 19b. Ma	iling Address (Street and Number or	ncia Moya Moya Rural Route Number, City or Town, Stat	e Zip Code)							
Baltimore, MD 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Nelson Freddy Soto Moya 714	7 Arlington Bly	vd #204 Falls C	22042							
e, MC 1 and 2 sl Health ar item 27	20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery,	Date 20c. Location - City o	r Town, State							
nor ages out of other	1 Burial 2 Cremation 3 Removal from State crematory of Nation	otherplace) al Memorial 0	14/2012 Falls C	hurch VA							
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	21. Signature of Funeral Service Licensee 2		H. Bacon Funer								
E E P E	Wanda C Bacon cc0361	A . I . I DUCOII I UIIC.									
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	Approximate Interval Between Onset and									
Medical Examiner	Immediate Cause (Final disease a. Multiple Injuries										
	or condition resulting in death) Due to (or as a consequence of):										
<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
i i	cause. Enter Underlying Cause (Disease of Figure that initiated events resulting in death) I set Due to (or as a consequence of):										
Ex susi de Ex	events resulting in death) Last Due to (or as a consequence of):										
be executed sician and unial - transit and oldical Examiner	UNPENDED AMENDED										
	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	ry							
ox 6876C eath certificate attending phys for use as the b	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna	ancy Month	Day Year							
b. Box 6876 the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)									
Records, P.O. Box 6876(The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the completed by Physician/Me.	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?							
of Vital Records, P.O. ng Physician: The law requires that the wher this certificate has been signed by increal director, page 2 should be detach in: To Be Completed by Pl			1 Yes 2 ✔ No 3 Pro	bably 4 Unknown							
Records, The law require: ficate has been sig, page 2 should bb.				utopsy findings available completion of cause of							
Recol The law cate has page 2 sl			performed? death? 1 ✓ Yes 2 No 1 ✓ Y								
	25. Was case referred to medical	26.Place of Death (Check									
f Vital Physician: or this certif ral director, To Be (examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other Nursir	ng Home 5 Residence 6 🗸 Othe	er: Scene							
	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending Oct. 7, 2014 September 28b. Time of Injury 28b										
Sior Attend r death ector: by the	2 Accident Investigation	1 Yes 2 ✓ No									
Division or spital or Attending tours after death. neral Director: After filled in by the function of the fun	3 Suicide 6 Could not be determined (Specify) Interstate/Express		28f. Location (Street and Number or Re or Town, State) I-95 @ Route 175, Jessup, MD	ural Route Number, City							
Division of Vital the Hospital or Attending Physician: hin 24 hours after death. The Function After this certificable filled in by the funeral director, dical Certification: To Be (29a. Certifier A Continue To the best of multipopulation double of the continue to the continu			tod.							
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	one) 2 Medical Examiner: On the basis of examination and/or invest										
P P P P P P P P P P P P P P P P P P P	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	onth, Day, Year)							
50	Caroe Hallan	O.C.M.E.	October 8, 2012								
	30. Name and address of person who completed cause of death (Item 23a)										
		. Baltimore Street, Baltimore	, MD 21223								
State Registrar	31. Date filed (Month, Day, Year) 22. Registrar's Signiture	A CAP A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0/7/2012 CHARLES WARREN MATTHEWS, SR. Physician/ 07:10 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. ocial Security Numb 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 212-22-4548 Months Days Hours 1₹ M 2 □ F Director 84 1/17/1928 MD Usual Residence of Decede : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Beltsville 1 Yes 2 No MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 11500 Cordwall Drive USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 1950- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 Ĭ950**–**52 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mailroom Supervisor-USDA 12th Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Frank Matthews t. Page 1 and 2 should b tment of Heelth and Mer tant: If item 27 is mark Iottie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn S. Matthews/wife 11500 Cordwall Drive, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any Injury or ot Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Natl Mem. 10-13-2012 Jaurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Resolvatru disease or condition resulting in death) Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as consequence of): attending physician and I for use es the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Day Year signed by the at Id be detached for 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an has this certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 1000 OCTUBER 7,2012 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVENUE, TAKOMA PAKK, MARYLAND MO, FACEP-TERRY JUDICIE Day, Registrar's Signatu State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lula Mae McClain 5:01a M 10/9/201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Cheverly Prince George's Community Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 69 578-60-3886 Director 1 M 2 XF 2/24/1943 KY Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Capitol Heights 1 Yes 2 No Prince George's MD with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 20743 USA 610 Millwoof Drive death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after copportunent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event. the Maximus once. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DC Public School System Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Secretary Be 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Spencer 17. Father's Name (First, Middle, Last) ည John Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Millwoof Dr. Capitol Hghts., MD 20743 Lolita McClain / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 10/14/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses Symberry buscoe 2294 Old Washington RD Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Enqueritistly list non-ditional if any, leading to immediate cause. Enter Underlying Examin burial-transi Cause (Disease or injury that initiated events resulting in death) Last dno and nding physician use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \(\subseteq \) Yes 2 \(\subseteq \) No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown been signature 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tes 2 NO 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be 3 Suicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item \$3a) (Type, Print)

Dr Cryckache Equin 3001 Hospital

Registrar

egistrar's Signatu

Five Cheverly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 4c. County of Death In vrs. last birthday 1 XM 2 F 69 03/10/1943 Maryland 10c. City, Town or Location

For State Registrar Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical **Examiner** 4a. Facility Name (if not institution, give **Funeral** 9. Birthplace (State or Foreign Director Usual Residence of Decede show notified at 10a. State 10d. Inside City Limits Director 28a-f Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Numbe 5 10f. Zip Code 10g, Citizen of What Country? other traumatic event, the Medical Examiner must be 23a Funeral 312 Mill Pond Lane, Apt. 404 21804 USA ritems death \ Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married è þ should be filed within 72 hours after Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify. Army "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Head Master Mechanic Pump Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Luther William Morris Doris Ethel Littleton ge 1 and 2 should it of Health and N : If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne L. Morris/Brother 23225 Royal Oak Rd, Quantico, MD 21856 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 s Date 20c. Location - City or Town, State ment of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ō cemetery, crematory or other place, Department of Important: If any injury or 4 Donation 5 Other (Specify) Springhill Memory Gardens 10/13/2012 Hebron, MD nature of Fu all Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Bompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Sma Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, coulding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine patrioava sician and burial-tran resulting in death) Last Due to (or as a consequing of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Po Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 1 🗆 Yes 2 🗆 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F the only one Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA 31. Date filed (Month, Day, Yea 32. Registrar's Signature 12 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ - 1 0 -6122 AM Dolores A. McInturff 2012 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Coastal Hospics at the Wice mico Lake If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 213-34-5141 1 □ M 2 🕱 F 74 02/04/1938 Maryland ould be filed within 72 mounts of Mental Hygiene.
If Mental Hygiene I marked other than "natural", or items 23a or 28e-f show is marked other the Medical Examiner must be notified et unatic event, the Medical Examiner must be notified et 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21804 100 Pacific Ave. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗀 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Domestic æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jesse D. Richardson Grace Miciotto other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 David J. McInturff/Husband 100 Pacific Ave., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If ii any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Springhill Memory Gardens 10/15/2012 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligen Name and Address of Facility 1 Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kith 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 5 OVARIAN Physician/ disease or condition resulting in death) Cancel Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 D Other (Specify) Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA TOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural injury 5 Pending ☐ Accident
☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H 68413 Sheehan D.O. Oct 10, 2012 and address of person who completed cause of geath (Item 23a) (Type, Print) 21802 heehan 31. Date filed (Month, Day, Year) Registrar's Signature State 2012 0C

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34594 State Registrar Certificate of Death 2. Date of Death 3, Time of Death 1. Decedent's Name (First, Middle, Last) Day 8:5A M Physician/ るのる Sharon Lee Mullinix Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospice C Willow i/∞ Coastal 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) Min Country 219-36-1673 Maryland Director 1 M 2 XF 06|13|1935 77 Usual Residence of Decedent Show 10d. Inside City Limits or 28a-f shov notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number er than "natural", or items 23a or the Medical Examiner must be by Funeral USA 21830 25300 Porter Mill Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Sharch MULLINIX White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) n and Mental Hygiene.
7 is marked other than "r traumatic event, the Med College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare Secretary 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ollie Belle Whitesell Page 1 and 2 should be Lester Snow injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other trauonce. 25300 Porter Mill Rd., Hebron, Maryland 21830 William Mullinix|husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 10 12 2012 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 22. Name and Address of Facility Holloway Funeral H. 501 Snow Hill Rd., 21. Signature of Funeral Service Licensee Home P.A., Salisbury, Maryland 21804 KinK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIRRHOSIS L IVE Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably A Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 certificate 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA ဂ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34595 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Armond Ethebert Merrill, 10 2012 7:48 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1847 Cypress Road Pocomoke Worcester 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Days 1 X M 2 🗆 F Months Hours Min Month, Day, Year) 4-14-1926 **Director** 220-16-7533 86 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MD Worcester Pocomoke 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 1847 Cypress Road 21851 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Navy Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify. Specify:Black "natural" Completed 3X Widowed 4 □ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Driver Board of Education Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Merrill Gertrude Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Armond Merrill, Jr./Son 1847 Cypress Road, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State Cremation, 10-10-2012 Dover, DE 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility917 W. Isabella St. Hennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MYELOMA MULTIPL E disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EN1) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be tay hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant
Unknown 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed s been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury Natural Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🙇 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 To the F the only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

HB 6

1604

32. Registrar's Signature

mi

12 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATYALIM.D.

D62172

MARKET ST. POCOMOKE CITY MD 21851.

10/8/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

imberg Magne (1	- For State	tate of I	Maryland /	Depai Cert	rtment of hificate of	Health and Death	d Mental	Hygie		ı. No.	201	2 3459
Physicia	_	tegtstrar 1. Decedent's Name (First, Mid	dle,Last)						Mo	te of Death nth	Dav	Year	3. Time of Death
Medical Examir	ner	Limberg Ma	_						Oc	tober 7,	2012		0559 hrs
		4a. Facility Name (if not institut I-95 North @ Route		et and number)		4	b. City, Town, or Jessup	Location of De			Howa		
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. la	st birthday)	If Under 1 Year			ate of Birth	(MM/DD/Y	YYY) 9. Bir Co	thplace (State or Foreign untry)
Director		229-93-0284	1 X M	2 F 3	6	Yrs.	Months Days	Hours N	viin.	2/30	/197		olivia
	_ L	Usual Residence of Decedent			10 01	Town or Locati							10d. Inside City Limits
w any		10a. State 10b. Count											1 Yes 2 XNo
Maryland 28a-f show d at once.	ğ		rfax		Ale	xandr	1a 10f. Zip Code			I 10	a. Citizen o	f What Cou	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	D				22306					ivia	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		7910 Stork		Was Decedent I	Ever in U.S	S. 13. Wa	s Decedent of His	panic Origin?	(Specify	Yes or No-	14. F	Race - Amer	ican Indian, Black,
eath w items	Funeral		Married	Armed Forces? Yes 2	X No	If Y	es, specify Cuban	, Mexican, Pue	erto Rican	, etc.)	'	White, etc.	
fter de		3 Widowed 4 D	ivorced If Ye		A NO	1 X	Yes 2 No	specify: B	oliv	'ian		city: Wh	
)36 thin 72 hours aftere. than "natural", edical Examiner	d b	15. Decedent's Education (Sp	ecify only hi	ghest grade com	pleted)		t's Usual Occupat ost of working life			one	16b. Kind o	of Business/	Industry
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Raul Magne		lori									amacho
y, MD 2121 and 2 should be fi [ealth and Mental] tem 27 is marked traumatic event,	10 10	19a. Informant's Name/Relation			her	1	Address (Stree	et and Number	or Rural I	Route Num	ber, City or	Town, State	e, Zip Code)
Baltimore, MD oemit. Pages 1 and 2 sho Department of Health and Important: If item 27 is niury or other traumati		Jesus Magne	Oliv	era			Stork						
re, land Heat Heat Fitem		20a. Method of Disposition 1 X Burial 2 Cremati		Pemoval from Sta	20b. F	Place of Dispos crematory or oth	ition (Name of cer her place)	metery,	Date	€	20c. Loca	tion - City or	r Town, State
MOFE Pages 1 ent of H int: If it		4 Donation 5 Other		temoval nom ota	" F	'amily	Cemete	ery 1	0/20	/12	Boli	via_	
Balti Permit. Departm Imports injury o	1	21. Signature of Funeral Service					lame and Address						al Home
		Wanda C. 7 23a. Part I. Enter the disease,	sacor	v cc	0361] 3	447 14t	h St.	, NW	Wash	ingt	on Do	C 20010 Approximate Interval
Physician Vedical		23a. Part I. Enter the disease, failure, List only one caus	se on each li	ne.		Do not enter t	ne mode or dying,	Suci as cardi	ac or resp	matory arro	ot, officer, t	or riodit	Between Onset and Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.	e	to (or as a conse	equence of	f):							
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be executed sician and urial - transit	cal	UNPENDED	dA	MENDED									
		IF FEMALE:		3c. If yes, outcome	ne of preg	nancy			-		23d. Da	ate of delive	ry
6876(certificate nding physes as the b	an/N	23b. Was decedent pregnant in past 12 months?		Live birth		2 F6	etal death 3	Ectopic pre	egnancy		Mor	nth	Day Year
OX 6876(eath certificate attending physion use as the b	sician/M		Jnknown g	Pregnant at	time of de	eath 5 0	ther (Specify)			-			
Division of Vital Records, P.O. Box 6876 Isl or Attending Physician: The law requires that the death certificate In Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the b	Phy	Part II. Other significant con	1 5		n but not re	esulting in the	underlying cause	given in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
P.O s that	ð	, a.c.,		····· 3						1 Yes	2 🗸 No	3 Pro	obably 4 Unknown
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Re The ficate	ပ	25. Was case referred to med	col				26 Plac	e of Death (Ch	eck only	Yes i	Z NO	1 🗸	res 2 No
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ViSi or Att fter de pirecti in by 1	iţi		vestigation ould not be	28e. Place of Ir	njury - At h	ome, farm, stre	eet, factory, office	building, etc.	28f.	Location (S	Street and I state)	Number or F	Rural Route Number, City
Divisior pital or Attencours after death teral Director: filled in by the	Certification:	4 Homicide	etermined	(Specify) Inte						or Town, S @ Route			
Divisior To the Hospital or Attend within 24 hours after death Jo the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying one) 2 Medical E	xaminer: Or	the basis of exa	ny knowled Imination a	lge, death occu and/or investiga	urred at the time, o ation, in my opinio	date and place in, death occur	, and due red at the	to the caus time, date	se(s) and m and place,	anner as sta and due to	ated. the cause(s)
To T With	Medical	29b. Signature and title of cer	an	d manner stated.				se number					fonth, Day, Year)
5	-	Comme	1/1	10000			0.0	.M.E.			Octob	er 8, 201	2
		30. Name and address of per	son who com	pleted cause of	death (Iten	n 23a)					I		
		Carol H Allan MD	Assista	ant Medical E	xamine	r 900 W.	Baltimore Str	eet, Baltim	ore, M	21223			
	tate	1917 6 10 1	ar) 2019	32 Registra		1º par	Ked						_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34597 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:09 P M 2012 Morgan Walter Parks October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 13914 South Springfield Rd. Brandywine Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Months Hours Min **Director** 1 🛛 M 2 🗆 F 577-20-7156 89 April 14,1923 Maryland Usual Residence of Deceder 28a-f show 10b. County 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Maryland Prince Georges Brandywine 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? with 1 Funeral 13914 South Springfield Road 20613 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces 1 X Yes 2 □ No If Yes, Give Year or Dates. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Body Repairman Auto Body Repair 6 Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic..... other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Jennings Parks Julia Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice J. Buckley/Daughter 15268 Round Hill Rd., King George, VA 22485 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 ី Cremation 3 🗀 Removal from State Brinsfield-EcholsCrem: 10/13/2012 | Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or a a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death signed by the a Id be detached f 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24a, Was an 24b. Were autopsy findings available page 2 prior to completion of cause of death? has autopsy performed certificate 1 Yes 2 No Yes the funeral director, 25. Was case referred to project 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. I Director: Af М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier l 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

et cause of death (Item 23a) (Type, Print)

926 Wood

1 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day Physician/ 6:14 P M 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Mechanicsville 37050 Newlands Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min 213-40-6963 1 □ M 2🏋 F **Director** 71 08/17/1941 North Dakota Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2X No Mechanicsville St. Mary's Maryland 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral USA 20659 37050 Newlands Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Navy of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Budget Analyst Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be file thent of Health and Mental rtant: If item 27 is marked or jury or other traumatic ew Bernice Juanita Onstine May 2 Leo George May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16507 Rolling Tree Road Accokeek, MD 20607 Jon R. Podorski 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Brinsfield-Echols Cre 10/16/2012 Charlotte Hall, MD 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Department o Important: If any injury or 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols Funeral Home, P.A M00817 30195 Three Notch Road Charlotte Hall, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) discuse Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown noNo Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' Yes 2 10 certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Plesidence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certificate: 1 Natural iniury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 🗆 within 2. only one) 29b. Signature and title of certifier 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 20627 (10) Rme フル MARRY 31. Date filed (Mo legistrar's Signatu State 8 Registrar

		A	Plea Amended Item 29b per	MD 10/01/2012	int in B	lack Inde	ible Inl	k. Ensure A	All Copies Mental Hyd	Are Legil	ble.
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, Maryland	nd 2 should saith and M n 27 is mai ier traumai	115	19a. Informant's Name/Relations Molly L. Hay		er			and Number or Rui			_{te, Zip Code)} urch VA 2204
Baltimore,	Page nent c ant: If iry or		20a. Method of Disposition 1 □ Burial 2 🙀 Cremation 4 □ Donation 5 □ Other (S				emat emat	ion Inc		20c. Location - C	•
Bal	permit. Departr Imports any inji		21. Signature of Funeral Service L	Stud		22. Nam Litt	e and Addres	FH 34 M	aple Av	veLittl	estown Pa 1
Ç	Medical Examiner)r	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Endough Due to (or as	STAC a consequer	COMA	R DI	SEASE	or respiratory arre	est,	Approximate Interval Between Onset and Death
.09	ate be executed hysician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequer						
. Box 68760	Attending Physician: The law requires that the death certificate be stream. The law requires that the death certificate be steps. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal c	death 3 Ecto	oic pregnanc r (specify)	y		23d. Date Monti	of delivery h Day Year
ds, P.O.	requires that the been signed by should be deta	þ	Part II. Other significant condition	ons contributing to death	out not result	ting in the underly	ng cause giv	ven in Part I.			ute to the cause of death? Probably 4 Unknown
Records,	The law recate has been page 2 sho	Completed							24a. Was a autops perfort	med? pri	ere autopsy findings available or to completion of cause of ath?
of Vital	ysician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ient 2 🗆 E	R/Outpatient 3 [Othe	ace of Death (Checer:		ence 6 🗆 Other	(Specify)
of \	ding Phys h. After this funeral d		27. Manner of Death 1 2 Natural 5 Pendir	28a. Date of inju	ury 28	8b. Time of injury	28c. Injury work	/ at ?		w injury occurred	
Division	I or Attendia after death. Director: Af d in by the fu	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	jury - At home	M ne, farm, street, fa		Yes 2 No	28f. Location (St City or Town		or Rural Route Number,
	Hospita Hours Funeral tely fille	Medical	(Check 2 Medical E	Physician: To the best o xaminer: On the basis of Nurse Practitioner: To the	examination a	and/or investigation	, in my opinic	on, death occurred a	at the time, date an	d place, and due to	o the cause(s) and manner state
	To the within 2 To the comple		29b. Signature and title of certifier	per ccnb		MD	29c. License			egd. Date signed (
	15		30. Name and address of person MEENAKSH	DAGAR	death (Item 2	23a) (Type, Print)	leans	5 St. 18	Baltim	ore, M	1 Der 29,2012
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2012 32. Registr	ar's Signatur	1. par	J				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 1:00p.n October <u>Jack Rottman</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital
Social Security Number 6. Sex Leonardtown If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 A 0370471932 Yrs Ohio Director 299-26-5827 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No St. Mary's Solomons Maryland 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20688 United States 11640 Asbury Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 0 ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Hygiene. other than "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government of Personnel is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental 2 Lela Belle Painter Rotis Budge Rottman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) prmit. Page 1 and 2 sh
D partment of Health ar
In portant: If item 27 is
any injurnor other trau 11640 Asbury Circle, Solomons, MD 20688 <u>Barbara F. Rottman/W</u>ife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 10/18/2012 Charlotte Hall, MD Signature of uneral Service Lice 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Sepsis Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of): Examine euclemonas Bacteremia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury sician and burial-transit Right Middle Due to (or as a consequence of): Middle that initiated events resulting in death) Last physician a Physician/Medical Physician; The law requires that the death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 4 Pregnant ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an certificate has page 2 autonsy performed? director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 7/12 MD of person who co pleted cause of death (Item 23a) (Type, Print) 25500 DOKATRO Leonard four MA oint RMG onth, Day, Year) State OCT 19 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Narine Rampersand State of Maryland / Department of Health and Mental Hygiene 2012 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day October 16, 2012 Medical Examiner 2111 hrs NARINE RAMPERSAD 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Foreian Months Hours Director 1 XM 2 F CountryTRINIDAD 578-06-7597 52 Yrs AUG. 22,1960 Usual Residence of Decedent in y 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 X Yes 2 No notified at once, PRINCE GEORGE'S BELTSVILLE Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 11614 OLD BALTIMORE PIKE 20705 TRINIDAD Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White etc. 1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: ASIAN INDIAN δ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LAW FIRM PARA LEGAL 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be RAMPERSAD RAMJANAM SONIAH MAHARAJ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD RAMDIAL F. RAMPERSAD/BROTHER .1614 OLD BALTIMORE PIKE, BELTSVILLE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10-20-2012 RIVERDALE, MD. Donation 5 Other Specify: CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Madical Death Immediate Cause (Final disease a Atherosc: erotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, per me, g933 11-14-12 sm X UNPENDED attending physician for use as the burial Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. **≙** 1 Yes 2 No 3 Probably 4 Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page certificate ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this ۵ 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural within 24 hours after death.

To the Funeral Director: completely filled in by the fu 1 Yes 2 No 5 | Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 18, 2012 O.C.M.E. victhal 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year, 32 Registrar's Signature State 22

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ 14:45 10/9/2012 Gloria Ann Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 215-76-5450 48 Director 1 M 2X F 12/02/1963 MD 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Valley Lee MD St. Mary's Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? pe ms 23a omnust be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must b. 20692 20265 Jackson RD USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Specify: Black 1 Yes 2 No Specify. 3 Divorced Completed Vear or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Barbara Ann Robinson Joseph Lawrence Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17334 Piney Point RD Piney Point, MD 20674 Barbara Ann Robinson/mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. George's Church Cem. 10/17/2012 Valley Lee, MD 22. Name and Address of Facility Briscoe-Tonic Funeral Fome 21. Signature of Funeral Service Lioch Paucolow 2294 Old Washington RD Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Phylician sersis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying The tolly as a cons Cause (Disease or injury tran that initiated events resulting in death) Last Due to (or as a consequer Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes ∠ x 9 ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CHF 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N hypertension 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:

and signed by the attending physician a Division of Vital Records, P.O. Box 68760 To the Hospital or Attenance, ..., within 24 hours after death.

To the Funeral Director: After this certificate has been signer.

To the Funeral in by the funeral director, page 2 should be r Sloria

the Maryland

Baltimore, Maryland 21215-0036

28a-f

5

Certificate: Medical

State

ျ

1 Yes 2 No

5 Pending

Investigation

Could not be

determined

McCurd

Manner of Death

Accident

4 Homicide

29a. Certifier

Suicide

1× Natural

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific

ER/Outpatient 3 DOA

M

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D006827

28c. Injury at work?

1 Tes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Xinpatient 2 🗆

(Month, Day, Year)

28a. Date of injury

St. Mary's Hospital 25500 Registrar's Signa

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 Residence 6 Other (Specify,

28d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elmer Micloth Rice 10/08/2012 3:16 p_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD Funeral 8. Date of Birth 218-38-7184 68 04/05/1944 **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD St. Mary's Great Mills Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45766 Ryan Lane 20634 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1972—1 X Yes 2 No 1978 Black, White, etc. by 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐ No Specify Specify: Black If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Air Force Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor mportant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Rice AnnieLeona Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Rice/Wife 45766 Ryan Lane Great Mills, MD 20634 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. 20c. Location - City or Town, State 10/10 2012 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd Waldorf, MD 20601 21. Signat of Funeral Service License Briscoe-Tonic Funeral Home Buch 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transi and that initiated events as a consequence of resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical **Division of Vital** t e funeral director. Be 26. Place of Death (Check only one) examiner? 2. No Hospital Other: 1 🗌 Yes မှ 1 Inpatient 2 KER/Outpatient 3 I DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1. Natural 5 Pending М 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prantioner: To the basis of my knowledge doesn't come of the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier H0071964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0,0 Registrar

ELME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year C. Richardson 2126 M 2012 ID 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisburi Wicomico Peninsula Regional Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 221-10-0047 Director 1 □ M 2 🛛 F Delaware 9-16-1920 92 Usual Residence of Dec ? Is marked other than "natural", or Items 23a or 28a-f shov treumatic event, Ihe Marical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours efter death with the Maryland Director 1 Yes 2X No Willards Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 21874 35914 Old Ocean City Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit, Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na eny injury or other treumatic event. Item." (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Baker Rhoda Olivette Conaway Tolbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 N. Saratoga Street, Salisbury, Maryland 21804 Betty Lou Kulp - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Wicomico Memorial PK 10-14-2012 Salisbury, Maryland 4 □ Donation 5 【XOther (Specify) Entombment Bounds Funeral Home 22. Name and Address of Facility 21. Signature of Figneral Service Ucense 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or comblic shock, or heart failure. List only one lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Bleeding Gastrointestinal Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use es the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 CUnknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💹 No 1 III Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending М 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifie 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The distribution of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0070129 10/11/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HB6 100 EAST CARROLL STREET, SALISBURY MOINUDDIN IRFAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

12 2012

barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar	Certificate of L			Reg. No. 201	2 3460			
Physician/ 1. Decedent's Name (First, Middle,Last)	D		2. Date of Dea Month October 9	ath	3. Time of Deeth 1228 hrs			
Victoria Ann 4a. Facility Name (if not institution, give street and number)	Rose 4b	City, Town, or Location of		9, 2012 4c. County of Death	L			
267 Wood Oak Court 267 Woodoak Co	urt	Glen Burnie		Anne Arundel				
Director 215-19-0761 1 M 2 X F 30	yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of B	irth(MM/DD/YYYY) 9. Bir Foreig /1981 Co	thplace (State or In Mary Land untry)			
Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location				10d. Inside City Limits			
	Glen Burn:	le			1 Yes 2 No			
10e. Street and Number 267 Woodoak Court		Of. Zip Code		10g. Citizen of What Cou	ntry?			
267 Woodoak Court 11. Marital Status 12. Was Decedent Ever	rin U.S. 13 Was I	21061 Decedent of Hispanic Orig	in? (Specify Yes or N	USA	can Indian, Black,			
11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X	If Yes	specify Cuban, Mexican,		White, etc.				
3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Y	es 2 X No specify:		Specify: Whi				
15. Decedent's Education (Specify only highest grade complete		Usual Occupation (Give) of working life. DO NOT		16b. Kind of Business/l	ndustry			
15. Decedent's Education (Specify only highest grade complete to the complete of the complete	Nurse				lealth Care			
Maryland Anne Arundel Debarture of Debart of Properties of Participal	n		s Name (First, Middle, borah	Maiden Surname) Worg	gan			
7 19a. Informant's Name/Relationship (Type, Print)				mber, City or Town, State				
Jeffrey Anton Rose/Husband	267 Wo		, Glen Buri	nie, MD 2106				
1 Burial 2 X Cremation 3 Removal from State	crematory or other Kalas Crema	place)		Edgewater,				
20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Nar	ne and Address of Facility	George P.	Kalas Funera	al Home			
July Mose	2973	8 Solomons I	sland Rd.,	Edgewater,	MD 21037 Approximate Interval			
Physician Medical Framiner 23a. Par() Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease								
Immediate Cause (Final disease or condition resulting in death) a. /Hypertensi		ascular Dis	case					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	nce of):							
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer Due to (or as a consequer devents resulting in death).					_			
MENDED4a, 23a		per me,g933	11-29-12	7 / / / / / / / / / / / / / / / / / / /				
d. Maring Physician and display to the control of the control o	pregnancy 2 Fetal	death 3 Ectopic	pregnancy	23d. Date of delivery Month	y Day Year			
Ö fa	of death 5 Other	(Specify)		1	,			
프 등 등 교 Part II. Other significant conditions contributing to death but	not resulting in the und	erlying cause given in Par	rt I. 23e. Did t	obacco use contribute to	the cause of death?			
Onesity, Fatty Liver Obesity, Fatty Liver				s 2 No 3 Prob				
The second of th			24a, Was autop		topsy findings available ompletion of cause of			
25. Was case referred to medical examiner?		26.Place of Death (1 ✓ Yes	2 No 1 Ye	s 2 No			
25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient:	2 ER/Outpatient			Residence 6 🗸 Other	: Scene			
27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Inju	y 28c. Injury at Work?		how injury occurred				
Natural 5 Pending Investigation 28e. Place of Injury - Could not be determined 4 Homicide determined (Specify)	At home, farm, street,	actory, office building, etc		Street and Number or Ru	ral Route Number, City			
O Logical Part of Land Country			or Town, S					
The part of the pa	wledge, death occurred tion and/or investigation	at the time, date and pla- , in my opinion, death occ	ce, and due to the cau- curred at the time, date	se(s) and manner as state and place, and due to the	ed. e cause(s)			
29b. Signature and title of certifier		29c. License number)CANE	29d. Date signed (Mor				
Thudan M. Kind J.R.	(tiom 230)	O.C.M.E.	DOME	October 10, 2012	<u>′</u>			
30. Name and address of person who completed dause of death Theodore M. King, Jr., MD. Assistant Medic		OM Baltimara Stra	est Baltimore Mi	D 04000				
	Jai Examino 00	o vv. Daillinote Stie	et, Daitimore, Wil	D 21223				

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jean Virginia Shaw Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Carroll Hospital Center Social Security Number If Under 1 Year 1f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 577-36-8696 84 1 □ M 2 🛣 F Director 11/19/1927 TA Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Exerciner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Carroll Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 514 Marshall Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) public schools teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Tessie Mann James Venceslav Anzulovic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Wielgosz/daughter 109 Warwick Drive, Lutherville, MD 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Carenesely cremanermachiermach) Department of Important: If any Injury or 10/04/2012 Hampstead, MD 4 Donation 5 Other (Specify) Inc. 22. Name and Address Preactives Funeral Home and Chapel, PA 21. Signature of Funeral Sep-Market Rese 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AORTIC ANTURYSA DISSECTING ASCENDING Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MD 21157 FRANCIS KHOO, MD 200 MEMORIAL AVE. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

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	1- For State Registrar				Certific	ate of	Death					Reg. No	. ZU	1	J4	10 U
Physician/ Medical Examiner	1. Decedent's Nam			2.5						2	. Date of De Month October	Day	Year	r	3. Time of D 1219 h	
Wedical Examine	Isael Sa 4a. Facility Name (MIL PER	LU Dal	mber)		41	. City, Tow	n, or Lo	cation of	Death	00.000.	. ,	c. County o	f Death		
_		urora Street	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Easton						Talbot			
Funeral	5. Social Security N	lumber 6.	Sex	7. Age (In	yrs. last birl	thday)	If Under	\rightarrow	If Under			,	A/DD/YYYY)	9. Birti Foreigi	hplace (State	or
Director	NL K.	1	M 2 F	31		Yrs.	Months	Days	Hours	Min.	01-0	4 – 1	981 ———	Gi	ratam	ala
	Usual Residence o														10d. Inside (City Limits
d how any	10a. State	10b. County Talbo	ot		East		n								1 Yes	•
the Maryland a or 28a-f sh- tiffed at once	10e. Street and Nu	mber urora S	Street	apt.	3		10f. Zip Co 21	ode 601				10g. C	itizen of Wh	at Coun	itry?	
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Marri		12. Was Der ed Armed F 1 Yes ed If Yes, Give Yes	orces?		If Ye	Decedent s, specify (Cuban, N	lexican,	Puerto F	cify Yes or I tican, etc.) spani		14. Race White	e, etc.	can Indian, B	lack,
ral",	3 Widowed		or Dates:		160	Decedent'							Kind of Bu	***		
hours Exan	15. Decedent's E				100.	during mo	st of working	ng life. D	O NOT u	se retire	d)				•	
5-0036 iled within 72 hour Hygiene. 1 other than "natur the Medical Exam.	Elementary/Sec	ondary (0-12)	College (1-4 OF 5+)		Cle	anin	_							g Co.	
cd wire	17. Father's Name	(First, Middle, La	st)										n Surname)			
215 be file ntal H rked ent, i	Vince	nte P	erez										Hern			
nore, MD 21215-0036 ages 1 and 2 should be filled within 72 hours after nt of Health and Mental Hygiene. tt: If item 27 is marked other transmatic event, the Medical Examinar other transmatic event, the Medical Examinar	19a Informant's N Vitalina Silvia	Perez-S	(Type, Print) alas/S	ister	19 2	b. Mailing 916 J	Address -Macl	(Street a	nd Numb rcle	er or Ru	ral Route N evela	nd,	City or Town	n. State 3731 - Md	Zip Code) 1 21	01
and 2 and 2 and 2 tem 3	20a. Method of Dis	position			20b. Place			of ceme	tery,		Date	200	c. Location -	City or	Town, State	
S 1 S 1 IL	1 Burial 2	Cremation Other Spec		rom State	Cemet Gener	erio al Co	erplace) mitar	ncil.	lo	11–9	-2012	1	an Ma Turlo	rco:	s, Gua Mary	toma land
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum	21. Signature of Fi					22. Na	ame and A	ddress o	f Facility		nie S Easto			ner	al Ho	ome

Physician //Medical Examiner

failure. List only one cause on each line

Immediate Cause (Final disease

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)

OCT 1 9 2012

Assistant Medical Examiner

32. Registrar's Signature

aSeizure Disorder

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

ļ	ertification: To Be Completed by Physician/Medical Examiner
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led in by the funeral director, page 2 should be detached for use as the burial - transit	dica
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	or condition resulting in death)	e to (or as a consequence of):			
Examiner	cause. Enter Underlying Cause c.	e to (or as a consequence of):			
dical	X UNPENDED X	MENDED 23a, pt. II, 27, pe #14.19a, b, 20b, c, perFH, C	r me,g934 12-10- 933,11/7/2012,WS	-12 sm	
Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Feta	death 3 Ectopic pregnal		23d. Date of delivery Month Day Year
Completed by Ph	Part II. Other significant conditions of Steatosis of the	ontributing to death but not resulting in the uncertainty $pprox 2$	derlying cause given in Part I.	1 Yes	
omple				autopsy performe 1 ✓ Yes 2	ed? death?
	25. Was case referred to medical		26.Place of Death (Check of	only one)	
o Be		pital: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nursin	g Home 5 Re	esidence 6 🗸 Other: Scene
tion: To	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	ury 28c. Injury at Work?	28d. Describe how	
Certification	2 Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - At home farm, street	, factory, office building, etc.	28f. Location (Street or Town, State	eet and Number or Rural Route Number, City te)
Medical C	one) 2 Medical Examiner: 0	 To the best of my knowledge, death occurr in the basis of examination and/or investigation and manner stated. 	on, in my opinion, death occurred a	t the time, date an	d place, and due to the cause(s)
₹	29b. Signature and title of certifier		29c. License number	2	29d. Date signed (Month, Day, Year)
_	0 = 1		O.C.M.E.		October 17, 2012

ack

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Interval

Between Onset and

Death

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Octobe. 2012 5:98 Stancell Earl 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) Mir 239-48-7678 1**X** M 2 □ F 78 March 12,1934 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 🙀 Yes 2 □ No Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20745 806 Irvington Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1X Yes 2 □ No If Yes, Give 1 0 956 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)

Energy Conservation

Veterans Cemetery

20b. Place of Disposition (Name of cemetery, crematory or other place)

Irvington Street

22. Name and Address of Facility Hodges

3910 Silver Hill Rd.,

Program Specialist

18. Mother's Name (First, Middle, Maiden Surname)

Nessie

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10/24/12

Couan

&

Fed. Govt.

20c. Location - City or Town, State

Cheltenham, MD

Suitland, MD. 20746

Edwards F.H.

20706

Physician Medical **Examiner**

Department of Health a Important: If item 27 is any injury or other trau once.

Examine Physician/Medical

For State Registrar

James

10a. State

MD

17. Father's Name (First, Middle, Last)

Stancell

1X Burial 2 Cremation 3 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

mb

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

Audrey Stancell/Wife

re of Funeral Service Licensee

Eddie

20a. Method of Disposition

Physician/

Medical

Examiner

Funeral

Director

28a-f show

23a or

tal Hygiene.
ed other than "natural", or items 23

alth and Mental Hygiene. 27 is marked other than retraumatic event, the M

be notified at

Examiner must

Director

Funeral

by

Completed

Be

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with the Maryland

within 72 hours after death

permit. Page 1 and 2 should be

Baltimore, Maryland 21215-0036

sician and burial-transit attending physician I for use as the buria signed by page 2 s certificate

To the Hospital or Attending Physician: The law requires that the death certificate be executed

has

Division of Vital Records, P.O. Box 68760

	23a. Fart L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Use to (or as a consequence of):			Approximate Interval Between Onset and Death		
ıminer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence off:				
dical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 1 Unknown 1 Ves 2 No 9 Unknown 1 Ves 2 Ves 2 No 9 Unknown 1 Ves 2 Ves 2				23d. Date of delivery Month Day Year	
ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE ROWAL DISENSE 1 Yes 2 No 3 C 24a. Was an autopsy				use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
Complet	performed2 deat					
Be (5. Was case referred to medical 26. Place of Death (Check only one)					
2	Hospital: 1 Yes 2 No					
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		work?	28d. Describe how injury occurred		
I Certii	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certificate:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier	_ ms	29c. License number 0007043		oate signed (Month, Day, Year)	

State Registrar

19+1

8118 GOODLICK RD LANHAM MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State		State of I	Marylar	-	artmen			and M	1ental Hy	•		21-7	- 0 0
_			Registrar 1. Decedent's Name (First, Middle	, Last)			Cei	uncau	OIL	eaiii	_	2. Date of De	Reg. I	No/	3. Time o	Death
Physic Me	cian/ dical		Mary Florence	[oml	inson									oay 2012 Year	7:30	
Exan			4a. Facility Name (if not institution			")				Location	of Death	_		4c. County of Dea		
- A		Į.	Alpine Assisted	Li 6. Sex		Age (In ure	last birthday)	If Under	amas	cus If Under	24 Hrs	8. Date of Bi	46	Montgom		
Funer Directe	_		162-26-8081 Usual Residence of Decedent		M 2 🖾 F		30 Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year	1932 Pen	thplace (State o buntry) nsylvan	
yland f shov	. 2	5	10a. State 10b. County			10c. Ci	ty, Town or Lo								10d. Inside C	ty Limits
e Mar r 28a	Director		Maryland Fred 10e. Street and Number	eric	k —		New Ma		0 1							2 💢 No
h with th ns 23a o nust be	Fineral		6531 North Sho	ce W	lay			10f. Zip	2177	4				Citizen of What Co ted Stat		
nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	٤	2	 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 		 Was Deceden Armed Forces Yes 2 If Yes, Give Year or Dates 	X No	1	Vas Deced FYes, spec	ify Cubar	n, Mexican	, Puerto I	cify Yes or No- Rican, etc.)	-	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	Completed		15. Deceder (Specify only highe Elementary/Secondary (0-12) 1 1			r 5+)	life. D	lent's Usua kind of work NOT use Homem	k done di retired)	uring most	of workin	ng		Kind of Business Own Home	/Industry	
and 2 be filed wental Hygisked other	To Be (ב	17. Father's Name (First, Middle, L Davis Conoway	ast)			<u> </u>	.rome m	anc I	18. Mothe		(First, Middle,	, Maide			
Mary d 2 should alth and M 27 is mar			19a. Informant's Name/Relationsh John Tomlinson				19b. Mailir 6531	g Address North	(Street a	nd Numbe re Wa	er or Rurai	Route Numbe lew Mar	er, City o	or Town, State Zi	7 4	
More, Page 1 and nent of Hei int: If item		2	20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Repecify)	emoval from Sta	te C	Place of Dispo cemetery, cren thaven	natory or ot	her place	э) (C)ct. 20	9, 012		Location - City or		nd
Baltimore permit. Page 1 a Department of H Important: If ite	ouce.	1	21. Signatur T Emeral S vice L				R Q	Name and estha 501 C	Address ven	s of Facility Funer	al S	Service	s,	Skkot Co Frederic	dy P.A.	
		\dagger	23a. Part 1. Enter the disease or shock, or heart failure. List o	complic	cations that caus	ed the deat									Approximat	е
Physicial		Immediate Cause (Find disease or condition resulting in death)								lar D)isea	se		4	Onset and I	
Medic: Examine	_	Advanced Dementia														
7 = 1	niner		Sequentially list conditions, if all y, leading to infinediate cause. Enter Underlying	uerice crj:												
50 te be executed nysician and he burial-transit	Examiner		Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or a	s a consequ	uence of):					<u> </u>				
50 te be exhysician he buriz				L d.												
876 tificate ng phy	Med		F FEMALE:													
Records, P.O. Box 6876 The law requires that the death certificat ate has been signed by the attending phage 2 should be detached for use as the	Physician/Medical	2	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ※ No 9 ☐ Unknown	23	c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 🗌 Feta tat time of a	al death 3	Ectopic pi Other (spe		/		<u> </u>		23d. Date of de Month		/ear
15, P.O. uires that the n signed by the	þ		Part II. Other significant conditio	ns cont	ributing to death	but not res	sulting in the u	nderlying ca	ause give	en in Part I				use contribute to		
Vital Records, sician: The law requires certificate has been signirector, page 2 should b	Completed	-										24a. Was auto		prior to	topsy findings a completion of c	vailable ause of
an: Th tificate tor, pa	Be Co		5. Was case referred to medical	T					26. Plac	ce of Deat	h (Check	1 Yes 2 No 1 Yes 2 No				
Vital visician: visicertific	일		examiner? 1 Yes 2 No	Но	spital: 1 🔲 Inpa	atient 2 🗆	ER/Outpatien	3 🗆 DO	Othor	r: 4 🗆 Nu	rsing Hor	ne 5 🗆 Resid	dence	6 X Other (Spec	Assis Living	ed
on of anding Ph ath. r; After th	Certificate:		7. Manner of Death 1 Natural 5 Pending 2 Accident Investig		28a. Date of in (Month, D		28b. Time of Injury	28 M	c. Injury work?	at	2	8d. Describe I	now inju	ury occurred		
DIVISION OF tal or Attending PP rs after death. al Director; After the			3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi							28f. Location (Street and Number or Rural Route Number, City or Town, State)				er,		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	2	(Check 2 ☐ Medical Ex	amine	r: On the basis of	examination	n and/or invest	gation, in m	y opinion	n, death oc	curred at 1	the time, date a	and plac	and manner as st ce, and due to the se(s) and manner a	cause(s) and mai	nner stated.
To t with To th			9b. Signature and title of certifier	6	6) am	ny			License i					ate signed <i>(Montl</i> ober 9,		
V			0. Name and address of person w						Neck	Rd.	, Ess	sex, MD	21	221		
St	ate		Date filed (Month, Day, Year)		32. Regist	trar's Signat	ture					•				
Regis	trar	L	OCTI	201	4 por	aces.	D. A.	arker								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Claudette Valandingham October 2012 6:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 12203 Brolass Road Cli<u>nton</u> Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 008-26-3525 1 □ M 2 🔀 F 74 1938 May 15, <u>Vermont</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Prince Georges Maryland 1 X Yes 2 No Clinton 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 12203 Brolass Road 20735 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th. Ith and Mental Hygier 27 is marked other tr traumatic event, the Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Clement Parent Bertha Marie Gagnon ge 1 and 2 should by t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trait 12203 Brolass Rd. Roger Valandingham/ Husband Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory 9. 2012 Waldorf, MD <u>:0ct.</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home any ir 3035 Old Washington Rd. Waldorf, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on ALh line. Interval Between Onset and Death Immediate Cause (Final Physician! disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to maneulate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence o). Hospital or Attending Physician: The law requires that the death certificate be executed -tran Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death signed by the aid be detached for 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) s after death.

I Director: After this ed in by the funeral d After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person wh

Leathernood

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Da103

old line Center Strike 302 Walderf

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lee Weaver, Sr. 4:00P Gary 2012 October. 16. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's **Mechanicsville** 38200 Edinborough Drive Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 579-88-8310 Director 1 **X** M 2 □ F 52 07/25/1960 **Maryland** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director 1 Yes 2 No Mechanics ville St. Mary's Maryland 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 38200 Edinborough Drive 20659 USA or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) ţ, U.S. Postal Service 4 Mail Carrier 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, .. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o Ronald Richard Weaver Zula Grace Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38200 Edinborough Drive Mechanicsville, MD Cathy Lee Weaver/ Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Charles Memorial Grds 10/19/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 Flandener 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ardiomnor disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Fibr Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Hy perteus Physician/Medical death certificate be Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death g Unknown 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Obesite 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed 1 Yes 2 No death? 1 Yes 2 No After this certificate Division of Vital 25. Was case referred to medical examiner? Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 24 hours after death. Funeral Lirector: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

15 Rme

within 2

31. Date filed (Month

only one)

29b. Signature and title of certifie

MD egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00040479

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 2, Physician/ 20°1′2 4:20 James Francis Wivell, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Emmitsburg 9807 Dry Bridge Road 8. Date of Birth (Month, Day, Oct 9, 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 🗆 F Maryland 84 212-24-7321 1927 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State Director r 28a-f sh notified a Rocky Ridge Frederick 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral with t USA 21778 10024 Four Points Road hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces Black, White, etc. ð 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " within 7 College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Agriculture Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ Roy J. Wivell, Sr. Helen L. Guise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11807 Harney Road, Taneytown, MD 21787 Dennis E. Wivell, son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter Schartery or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/03/2012 Winfield, MD Carroll Crematory 22. Name and Address of Facility Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 33a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PARKINSON'S disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner URINARY TRACT Sequentially list conditions, Examine Due to lor as a consequence of if any leading to himself cause. Enter Underlying DISEASE a ending physician and for use as the burial-transit Cause (Disease or iinjury CORON ARY ANTERY that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical MELLITIS Hospital or Attending Physician: The law requires that the dealh certificate be DIABETES ONSET APHLT 09289 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) a 🗍 Unknown 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, HYPERTENSION 1 🗌 Yes 2 4 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HYPERCHOLESTER LEMIA page 2 s autopsy performed death? OSTEOPOROSIS 1 ☐ Yes 2 ☐ NO certificate Division of Vital 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? 2 **N**o Hospital: Other: 4 \(\text{\text{Nursing Home}}\) 5 \(\text{\text{Residence}}\) 8 Residence 6 \(\mathbf{X}\) Other (Specify) Sovis 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 24 hours after death.
Funeral Director: After thieted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 1 Natural 5 Pending 2 \square No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

275

within 2

State Registrar

Medical

29a. Certifie

30. Name apro

3 🖂

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MP1296368

524 S.WASHINGTON ST. GETTYS BURG

00.7015212

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 4:30 A V. Frances Alluisi 10-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Towson Towson Baltimore 5. Social Security Number Date of Birth (Month, Day, Year) 03/02/1922 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 1 F MD Director 217-18-2814 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Madical Event that 3 and the ruttilisd at Director 1 ☐ Yes 2 ☑ No MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or ismy injury or other traumatic event, the Wadical Experience, ust the majorial progress. U.S.A. 8413 Pleasant Plains Road 21286 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify. δ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Office Worker Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Joseph Scandaliato Concetta Bucalo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8413 Pleasant Plains Road Baltimore, MD Barbara Alluisi, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/2012 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Parkwood Cemeterv 22. Name and Address of Facility Leonard J. Ruck, 21. Signature of Funeral Service Licensee 5305 Harford Road, Baltimore, MD 21214 aubnoye 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician emen! disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Upper Gasterointestinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Perte and Due to (of as a consequence of) burial-Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 **N**0 Division of Vital 1 ☐ Yes 1 ☐Yes 2 No Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospitai or Attending 1 Natural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29c. License number HC05HH2H 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Luther Ville IMD 21093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1012 Fallscrof Asudi 32. Registrar's Signature Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25,27,28a-f, per me, g933 11-7-12 sm State of Maryland / Department of Health and Mental Hygiene for State Registrar 34615 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Ahalt Amos 0500 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Traumo Center If Under 1 Year If Under 24 Hrs. 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 217-42-7758 Usual Residence of Deced 1 😡 M 2 🗆 F 69 1/9/1943 MD 28a-f show 10b. County 10d. Inside City Limits items 23a or 28a-f sho her must be notified at 10a. State 10c. City, Town or Location Director MD Frederick Jefferson 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21755 USA 3806 Jefferson Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Examiner Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after an "natural", o Medical Exam 1 ☐ Yes 2 No Specify. Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the machinery sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Amos A. Ahalt Helen Morrison other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ronald Ahalt (Brother) 3641 Jefferson Pike, Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Reformed Cemetery 10/10/2012 Jefferson, MD 5 Other (Spe 4 Donation 21. Sign the of Funeral Fervice ²² Name and Address of Facility Donald B. Thompson Funeral Home Me POB 18, Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or contion resulting in death) Enysician/ Medical Due to (or as a consequence of): **Examiner** CERTIFICATION APPROVED BY NEDICAL EXAMINER day Iraumah'c inlur brain Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death be detached the 9 Unknown been signed by Part . Other significant conditions contributing eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director: page 1 Yes 2 No 1 ☐ Yes 2.Z 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 5 Pending subject fell 1 Tes 2 🕱 No unknown M 2 X Accident Investigation 6 Could not be unknown 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3806 Jefferson Pike 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Jefferson, MD. Home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 3a) (Type, Print)

State Registrar

			Please	Type or Print in AMEND ITEM# State of Maryla	Black Indelil 26perPHYS, C	ple In	k. Ensure	All Copie	s Are	Legible.			
		•	For State Registrar		Certifica			vicinal riy	Reg. No.	2012	34616		
	Physicia		1. Decedent's Name (First, Middle, Last	1-dams	(im5					2. Date of Death Month Day Year FO ZZ FZ 1935			
به معر	Medio Examir		4a. Facility Name (if not institution, give: Pedi & SULA RIGIL	Street and number)	L Centre 4b. Cit		r Location of Death	1	1	County of Death	1 '		
	Funeral Director		5. Social Security Number 6. Se 390-36-74441	x 7. Age (<i>în yr</i> s	3 Yrs. If Unc	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 5 - 22	y, Year)	Cou	nplace (State or Foreign intry) SCONSIN		
	aryland e-f show fled at	Director	10a. State 10b. County MD Wicom		City, Town or Location Qua	antic	:0				10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
	with the M 23a or 28 1st be noti	Funeral Dir	10e. Street and Number 6160 Quantico Ro	ad	10f. Z	ip Code 2185	56		-	zen of What Cou USA			
9036	1 end 2 should be filed within 72 hours efter death with the Maryland if Health end Mental Hygiene. Item 27 is marked other than "netural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1	If Yes, sp	ecify Cuba	lispanic Drigin? (Span, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		4. Race - Amer Black, White Specify: Wh			
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	nd 2 shoul ealth end ! m 27 is m: er trauma		19a. Informant's Name/Relationship (Ty, Lee Adams (Ex-Wif		19b. Mailing Addre 7814 Fa1				-	-			
Baltimore,	Page nent c ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Polation 5 ☐ Other (Specify	Removal from State A	Place of Disposition (Na cemetery, crematory or tlantic Cre	other place mator	y 10/2	Date 5/2012	Gle	ation-City or n Burni	e, MD		
Bal	permit. Pag Depertment Important: any Injury c		21. Signature of Funeral Service License	Downe	22. Name a Gary 7250	nd Addre L. Ka Washi	ss of Facility Nufman Fu Ington Bl	neral Ho	ome a	t MMP, e. MD 2	Inc. 1075		
-	nysician/ Medical		23a. Part 1. Ener the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused the de e cause on each line. a. AHUOSU	eath. Do not enter the mo	de of dyin		or respiratory ar	rest,		Approximate Interval Between Onset and Death		
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	executed an and irial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Chyonic Due to (or as a conse	Kidney	dise	euse, 8	tage 4	!				
9		dical		d						:			
. Box 68760	Attending Physicien: The law requires that the death certificate be ar death. Fridest After this certificate has been signed by the attending physicient the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					very Day Year			
s, P.O.	ires thet t signed b id be deta	ρ	Part II. Other significant conditions co	ntributing to death but not r	esulting in the underlying	j cause gi	ven in Part I.		obacco us Yes 2		the cause of death?		
Division of Vital Records,	The law require cate has been signate page 2 should I	Completed						24a. Was auto perfo	psy ormed2	24b. Were auto prior to c death?	opsy findings available ompletion of cause of		
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Ž	Physic this co aldire	욘	1 ☐ Yes 2 No 27. Manner of Death	lospital:			4 ∐ Nursing H	ome 5 Thesi	-		(y)		
o uo	ending l sath. or: After he funer	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work 1 🗆		28d. Describe t	now injury	occurred			
>	5 € 5 ⊆		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factorify)	ry, office		28f. Location (5 City or Tov		Number or Run	al Route Number,		
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check 2 L Medical Examir	cian: To the best of my kno er: Dn the basis of examinat e Practitioner: To the best of	ion and/or investigation, in	n my opinie	on, death occurred a	at the time, date a	and place, a	and due to the c	ause(s) and manner stated.		
	vithi Com t		29b. Signature and title of certifier	10.10		lc. License	number		29d. Date	signed (Month,	Day, Year)		
	X		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type, Print)	RØS	5340I		10	-23-2	UIL		
	1,4,		Laura Crum CRA	if 1346 S.	Division St S	mile	103 Sali:	Sbury, 1	1D 2	1804			
	Stat Registra		31. Date filed (Month, Day, Year) OCT 3 1 2012	32. Registrar's Sign	hature			,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland 7 Department of Health and Mental Hygiene 0 | 2 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ellen Onerya Brazier 26 9:40 PM 2012 0ctober Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Oak Crest 8800 Walther Boulevard Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral . Social Security Number 212 20 3207 8. Date of Birth Days Hours Min. (Month, Day, Year) 89 **Director** 1 □ M 2X□ F 9-22-1923 Maryland 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Baltimore 1 Tes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a odical Examiner must be Funeral USA 21234 8800 Walther Boulevard 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: White 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy njury or other traumatic event, the Mones. Homemaker Be 17. Father's Name (First, Middle, Last)
Henry Kyllonen 18. Mother's Name (First, Middle, Maiden Surname) Anna Marie Pulkkinen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred L. Brennen, Jr. Attorney 21221 825 Eastern Avenue Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 10/27/12 4 ☐ Donation - 5 ☐ Other (Specify) Metro Crematory Baltimore, Maryland 21. Signal Confund al Service Ligenspe 22. Name and Address of Facility Lassahn Funeral Home 401 Belair Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Dav Pregnant at time of death ed by the a detached 1 1 ☐ Yes 2.2 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 1 🗌 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 → No Be 26. Place of Death (Check only one) ٩ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 Yes 2 No 5 Pending after death. Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical within 24 hou

To the Funer

completely fill 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The critifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Ilue M. Brazier R067343 10-26- 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blvd. Baltimore, MD Alice M. Brazier State Registrar

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9

-26-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Hazel Bowen Medical October 2012 8:10P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richie Hospice Baltimore Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 9 1926 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Baltimore City, MD **Director** 212 22 5417 1 M 2 X F Usual Residence of Dec 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Baltimore County 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9218 Orbitan Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ★ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. à 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Housekeeping-Own Home N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Christian Lettan Elsie Hardesty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9218 Orbitan Road Baltimore, Maryland 21234 Clifford L. Bowen (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Metro Crematory Inc October 29, 2012 4 Donation 5 Other (Specify) Baltimore, Maryland at re of Funeral Service Licensee 22 Namaand Address of Facility Tassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Days Sequentially list conditions, ary, leading to immediate cause. Enter Underlying Due to for as a consequence of: ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other s inificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy o Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific. by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Marner of Death
1 Natural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) Kbired Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 2012 D. 3131 Enclave Court MD 31. Date filed (Month, Day, Year) 31

DHMH 17 Rev 06-2011

Registrar

8:10P.M

4/94/01

2012

12-08050 Unique M. Booth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 34519
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	Reg.	No.	
Physici Medical Exam		1. Decedent's Name (First, Middle, Last) Unique Mercedes Booth	2. Date of Death Month D October 24,	3. Time of Death 0135 hrs	
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 217-55-8719 6. Sex 1 Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Bird 1999 Col	
and show any	or	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 711 Edmondson Avenue 10f. Zip Code 21201	10g.	Citizen of What Cour	
ter death ", or ite	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:	ican, etc.)	14. Race - Ameri White, etc. specify: Bla	ck
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21215-0036 wild be filed within? Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last)18. Mother's Name (IMichael A. Booth, Sr.Eugenia	Gale		
MD 2 nd 2 shou alth and N m 27 is n	2	19a. Informant's Name/Relationship (Type, Print) Eugenia Gale (Mother) 20a. Method of Disposition 19b. Mailing Address (Street and Number or Ru 711 Edmondson Ave.	Baltim	ore, MD	21201
Page nent or oth		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Dogation 5 Other Specify: On-Site Crematory	2/2012	Oc. Location - City or Baltimor	e, MD
Balt Permit Departi Import Infort	J	21. Figurityle of Funeral Service 22. Name and Address of Facility TOSEPH Brown 2140 N. Fulton 24a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or n	Jr. F Ave. B	uneral H	ome PA D 21217 Approximate Interval
/Medical Examiner	1	ailure. List only one cause one on line. It imediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Between Onset and
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760, icate be executed physician and the burial - transit	Medica	■ UNPENDED AMENDED 23a,pt.II,27,per me,g935 1-23-1	3 sm	23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/	23b. Was decedent pregnant in the past 12 months? 1	;y	Month D	ay Year
ires that the signed by the detached	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Repaired Tetralogy of Fallot and Cerebral Palsy	23e. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 Unkn		
Division of Vital Records, talor Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be an in by the funeral director, page 2 should be a second to be a should be	Completed		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Vital Rec ysician: The l his certificate l director, page	B	25. Was case referred to medical examiner? 1 V Yes 2 No No No No Other Norsing	· · · · · · · · · · · · · · · · · · ·	sidence 6 Other:	
ion of V tending Phy eath. tor: After th	tion: To		3d. Describe how		
Division pital or Atto ours after decembered Director filled in by the contract of the contrac	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Stre or Town, State	et and Number or Run	al Route Number, City
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and during the desired of the place of the p			
F # F S	M	29b. Signature and title of certifier 29c. License number O.C.M.E.	1	9d. Date signed (Mon. October 25, 2012	
	- 1	30. Name and address of person who completed case of death (Ilem 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re, MD 21223	3	
St Regist	ate rar	Russell Alexander MD. Assistant Medical Examiner 900 W. Baitimore Street, Baitimore	COME		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 25 2012 Townson P. Burkindine 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosedale Baltimore Square Hospital FRANKLIN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Months Min. Days Hours 1**⊠** M 2□ F Maryland 216 20 7562 85 08/26/1927 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c, City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2☐No Directo Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 965 Martin Road 21221 United States 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 DXes 2 □ No 21215-0036 1 ☐ Yes 2X No Specify Specify: White If Yes, Give Year or Dates: WWII ģ 3 ₩ Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Clerk Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Frederick Hall Burkindine Roberta Herman Jones ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2837 Ontario Road Parkville, Maryland 21234 Robert A. Burkindine (son) Saltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 ☐ Burial 2 ★ remation 3 ☐ Removal from State Bayview Crematory Inc. 10/29/12 | Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Federal Service Licensee 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1 Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immedian Cause (Final Inflammatory Response Physician Stemic disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Esophageal

Due to (or as a consequence of): Tear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed mallory - weiss Tea the burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria by Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No o 9 D Unknown <u>۵</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Hospitalst 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Sd. Dr., Baltimore, MD. 21236 NITH SANGRAMPURFAR, 9000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 27, 2012 Physician/ **BROOKS** COLLINS MARGARET 5:35 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore County OAK CREST VILLAGE RENAISSANCE CENTER Packville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Days 015-03-7199 **Director** 1 □ M 2 💢 F 103 Apr. 7, 1909 Ireland Usual Residence of Decedent or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💢 No Maryland Baltimore County Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21234 USA 8832 Walther Boulevard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. Yes 2 X No 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Residence Honenaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, is B B 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Catherine Moran Collins Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 629 Sussex Road, Towson, Maryland 21286 (Son) Bernard F. Brooks Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Nov 2, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 21. Signature of curious Service Vicehset MITCHETT WEDEFILD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition equation)

a.

Outhermes Disease Approximate Interval Between Onset and Death Physician Medical resulting in death) [/]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam After this certificate has been signed by the attending physician and it funeral director, page 2 should be detached for use es the buriel-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate hempletely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) Be B **Division of Vital** examiner? Other: 2 □**1**146 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA |요 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Vertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

01

Bracks

Margart

Parkville MD 21234

who completed cause of death (Item 23a) (Type, Print)

8800 Walthor Blua

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct. ^{Day}2012 Billie L. Brown 21, 8:00a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5928 Cecil Avenue Gwynn Oak 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Days 400-60-5964 **Director** 1 □ M 2XXF 68 July 12,1944 West Virginia item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Modical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 No MD Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 **USA** 5928 Cecil Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: should be filed within 72 hours eft. end Mental Hygiene. is marked other than "natural", If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Florist Floral Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Oliver Staten Hazel Marie Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pege 1 and 2 sh Depertment of Heelth er Important: If item 27 is any injury or other trau 5928 Cecil Avenue Gwynn Oak, Maryland 21207 Dennis H. Brown- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/25/2012 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Brown 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of): Exami anding physiclan and use es the burlal-transli that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month ed by the e P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hupertensi Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending work? 1 Yes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signate who completed cause of death (Item 23a) (Type, Print) 1120 North Rolling Road Bullimore, Haryland 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G933 11/27/2012 JH state of Maryland / Department of Health and Mental Hygiene																		
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	Decedent's Name (First, Middle, Last) Physician/ Tda						Virginia Bower						Date of Death Month Day Year			3. Time of Death		
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	items	Funeral	11. Marital Status		2. Was Dece	lent Ever in	J.S.	13. W		ent of Hi	spanic Orig	in? (Spe	cify Yes or No-				an Indian,	\dashv
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1	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Med only one) 3 Cest	ا کے amin Nurse کرنے	er: On the basi	s of examina	tion and/or	invest	igation, in m	ny opinio	n, death oc	curred at	t the time, date a	and plac	ce, and due	to the ca	use(s) and manner sta	ited.
リ	6 4 kg		29b. Signature and title of ce	nfier					29c.	License	number	7		29d. D	Date signed	(Month,	Day, Year)	
	O		30. Name and address of pe	son who co	mpleted caus	e of death (I	em 23a) (Ty	ype, P	rint)	ال	0 02	- O.	01204 04	ا ا	AAID	0	IAI	
	Sta	te.	31. Date filed (Month, Day, Ye	NUQY(32. Re	egistrar's Si	LCCC nature	14	J1V4	3	C 13	H	muya	7	YIV		401	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34624 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28^{Day} Physician/ Virginia Barnes Oct 2012 Year 12:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sun Valley Assisted Living Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 218-09-4307 Director 1 □ M 2 🛣 F 92 Jan 14, 1920 Maryland Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified MD Carrol1 1 Yes 2x No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Ridge Rd. 21157 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Race - American Indian. by 1 Never Married 2 Married Yes 2XXNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Joe Grimm Ford Parts Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter J. Roe Marie Huson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Serra (Daughter) 6123 Emerald Lane Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 😾 Burial 2 🗆 Cremation 3 🗀 Removal from State Lake View Memorial Park 11/1/2012 Sykesville, MD 4 Donation 5 Other (Specify) Signature of Eur Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, DM 21784 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schenic disease or condition / elles Medical resulting in death) Due to (or as a consequence of) nert **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exam lor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Įõ Month Day Pregnant at time of death 5 Other (specify) Year ed by the at detached for 1 Yes 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? ASSISTED LIVING Other: 4 Nursing Home 5 Residence 6 Other (Spec 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 🔲 Yes 2 🔲 No 28d. Describe how injury occurred 5 Pending 1 V Natural injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital (24 hours a To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one 29b. Signature

31. Date filed

wed sul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO

32. Registrar's Signature

DHMH 17 Rev 06-2011

29c. License number

0806

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year CASTELLA BROWN 3.04 A M Octobe 23 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Gounty of Death **Examiner** BALTIMORE MEDSTAR HARBOR HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (În yrs. last birthday) Hours 1352 155 **Director** 1 M 2 F 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Completed by Funeral Director MD 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 "natural", or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, /Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Clarinth 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur 22. Name and Ad ress of Facility ton Kus Balto. MD 21239 23a. PM / Eyler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Kenal Acute disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Elevation if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Zardlac Arrest the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? certificate 1 Yes 2 No _ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Hospital Other: 2 No 10 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending injury 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowl

Registrar

DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

Kulasegaram

Skandares

T 3 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Skandara

Registrar's Signature

29c. License number

RES 001

S. HANOVER

STREET

29d. Date signed (Month, Day, Year)

BALTIMORE

23

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Barnes Mue obec 2720 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore if Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 215-74-6022 46 06-03-1966 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show 1 ☐ Yes 2 √2 No Director items 23a or 28a-f s ner must be notified Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 319 Bright Oaks Drive 21015 Funeral United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or than "natural", or iter the Medical Examiner 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. Technician Maintenance 12 years ith and Mental Hygi 27 is marked other r traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Barnes, Sr. Mary Hopkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t Mary H. Barnes (Wife)
20a. Method of Disposition 319 Bright Oaks Drive Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>o</u> = o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If i any Injury or once, Hilltop Service Corp 10/31/2012 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 PC Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sis /Medical Due to (or all a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) physician and s the burial-transi The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) signed by the att ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be director, page 2 s autopsy performed? 25 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury

"footh Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Dea t Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (check only

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; Afcompletely filled in by the fo within 2 To the I

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RE5-000 6Ctobe(27,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Matthew Singleton MD

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

3 0 2012

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 28°, 2012 1:00 A M Physician/ October Bak Patrick Ronald Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Montgomery Hospice Casey House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) 6. Sex Social Security Number Funeral Days Hours (Month, Day, Year) Months 212-52-0449 1 ፟M 2 □ F Director **Yrs** January 31, 1950 Minnesota 62 Usual Residence of Dec 10d Inside City Limits 28a-f show 10c. City, Town or Location 10h County rismarked other than "natural", or items 23a or 28a-f shor straumatic event, the World Examiner must be notified at 10a. State within 72 hours after death with the Maryland rector 1 Yes 2 X No Mount Airy Carrol1 Maryland 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Numbe Funeral 21771 United States 6411 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Electronics President/CEO Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be file ဂ္ Irene Hutton Anthony Frank Bak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11715 Tifton Drive, Potomac, Maryland 20854 1 and 2 s f Health a item 27 i Martin J. Bak / Brother or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition October 31, cemetery, crematory or other place)
Montgomery
Crematorium, Inc Department of H Important: If its eny Injury or ot 1 Burial 2 X Cremation 3 Removal from State Page Bethesda, Maryland 2012 Inc. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Head and Neck Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical P.O. Box 68760 es 1 IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day ò signed by the at d be detached for Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy completely filled in by the funeral director, page 2 performed? Yes 2 K No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 🗌 Yes 28b. Time of 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death injury 5 Pending X Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

Within 2

CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

only one

29b. Signature and tiffe of certifier

Debrah Miller, 31. Date filed (Month, Day, Year)

3 E-Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

R143201

29d. Date signed (Month, Day, Year)

10.28.12

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 26, 2012 Physician/ 11:27 P M Merson Booth Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5508 Brite Drive Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours 469-26-6982 Director 1 X M 2 □ F 88 Yrs March 21, 1924 Minnesota 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Examinal must be retified at 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5508 Brite Drive 20817 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1942 – 1946 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) U.S. Government Nuclear Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Merrill Booth Marguerite Emelia Mossing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Booth / Wife 5508 Brite Drive, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery crematory or other place) Crematorium, Inc. October 30, 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 2012 4 Donation 5 Other (Specify) 21. Sign of re Furley Service Const 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 2/12 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 Physician/ disease or condition resulting in death) Parkinson's Disease vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Attending physician and completely filled in by the Attended in each search and the article of the article of the search of the sea that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 MC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

11+1

31. Date filed (Month, Day, Year) 0CT 3 0 2012 Registrar

State

29b. Signature

Robert Blee, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License numbe D23556

5215 Loughboro Road, N.W. #440, Washington, D.C. 20016

29d. Date signed (Month, Day, Year)

October 29, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Pecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day nown 10:28 AM 20/2 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES MOSPI BALTIMORE Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country Director 1 M 2 F S.C. permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important: If item 27 is merked other than "naturel", or items 23a or 28a-f show my hjury or other treumatic event, the Model Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3702 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aniversit Be Father's Name (First, Middle, Last) 18. Mother's Name First, Middle, Maiden Surname, nttie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State rematory 4 Donation 5 Other (Specify) 21. Signature Funeral Service Lice 22. Name and Address of Facility March ton Fass Butto. mo 21223 23a. Pal 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a gunsaguence off within 24 hours effer deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, pege 2 should be detached for use es the buriel-trensi lew requires that the deeth certificete be executed that initiated events Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2010 1 🗌 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 🗌 Yes 2 🗆 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 405

DHMH 17 Rev 06-2011

State

Registrar

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N- Eutow

OCT 3 1 2012

31. Date filed (Month, Day, Year)

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2/20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 RUTH L. COGGINS Medical OCT 12AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8804 Walther Blvd. Apt. Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1-29-1923 **Funeral** 5. Social Security Numbe 217~14~9718 9. Birthplace (State or Foreign Min. Hours Director 1 M 2 K F 89 MD. permit. Page 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Heelth end Mertiel Hyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show eny injury or other treumetic event, the Medical Everning must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore County Maryland Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8804 Walther Blvd.Apt. 3206 21234 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 🏋 No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: ¥⊠ Widowed 4 □ Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) A. & P. Food Stores 1013 8th grade N/A Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Frantz Roxie Mummert 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard N. Coggins (Son) P. O. Box 145 Kingsville, Md. 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Druid Ridge Cemetery tXX Burial 2 ☐ Cremation 3 ☐ Removal from State 11-1-2012 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 21. Sign ure of Funeral Service Licenses 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCNO Physician disease or condition Month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury) Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the deeth cartificate be executed within £4 hours after deeth.

To the Funeral Director-After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 🗆 Yes 2 🗷 No Yes 2 25. Was case referred to medical B 26. Place of Death (Check only one) Certificate: To 1 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Projection. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descripting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29c. License number mo 26th DJ 3115 M 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21234 Jeff Land 8f00 Parkerille Walth ma 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

10/26/12

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Daisy Ruth Colson 10:454 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore NOS Hospita If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Country) 239-34-2986 Director 1 □ M 2 🗓 F Yrs. 90 10-28-1922 NC ir then "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 10b County within 72 hours efter death with the Meryland 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🛛 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8821 Meadow Heights Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: African-American Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i Hygiena. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) permit. Pege 1 and 2 should be fliad with Dapartnent of Heelth and Mantel thygier Importent: If item 27 is marked other ti any flury or other treumatic event, the once. School Teacher Massachusett School Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Samuel Crowder Cassie Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Chambers/Nephew 8821 Meadow Heights Rd., Randallstown MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11-5-2012 Brentwood, MD 21. Signature of Funeral Service Licen Wylie Fineral Home P.A. of Balto. Co. 22. Name and Address of Facility 9200 Liberty Rd Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attanding Physicien: The law requires thet the obsent certilicate we environment of the hours effar deeth.

To the Funarel Director: After this certificate has been signed by the ettending physician end completely filled in by the funerel director, page 2 should be detached for use as the burial-transit Hospital or Attanding Physicien: The law requires thet the daeth certificata be executed 24 hours effar deeth.
Funarel Director: After this certificete has been signad by the ettending physician end Due to (or as a consequence of): Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ♣ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မြ 1-Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide м Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6275 2014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455)ee neale Will

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

UUI 3 1 2012

.32. Registrar's Signature

✓ DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34635 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month : 00 PM () Medical 4a. Facility Name (if not institution give street and number) **Examiner** 4b. City-Town, or Location of Death 4c. County of Death niversita Le Quite M 1 Year Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Director** 219-21-2808 1 M 2 X F 24 01/01/1988 Maryland Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore 1X Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 808 Wrenridge Avenue USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō by 1 X Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify:Black "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Disabled vear Disabled permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E.Curry Sharron Lightsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 E.Belvedere Ave.Baltimore MD.21212 Sharron Frieson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/25/12 cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holv Redeemer Cemetery Baltimore,Maryland Signature of Funeral Service Lic 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau ryal Between Approximate and Death Immediate Cause (Final empo lux Physician/ disease or condition Medical resulting in death) consequence of) **Examiner** Sequentially list conditions if any leading to immediate Examine Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending p IF FFMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Onknown Month 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 1 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner - eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director; After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No hours after death 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I 29a. Certifier Griffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed (above of death (Item 23a) (Type, Print) Paca SAPA 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jefferey Corbett	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012 346
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year October 25, 2012 3. Time of Death October 25, 2012
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital 8 Agnes Hospital
Funeral Director	5. Social Security Number 218-62-7597 1 N M 2 F 58 Yrs. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit
rland -f show once	MD N/A Baltimore 1 ∑ Yes 2 □N
the Maryland s or 28a-f sh stified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA USA
fier death with 1", or items 23 ter must be no y Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes, Specify: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Houseman 16b. Kind of Business/Industry Hotel
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) Clarence Corbett 18. Mother's Name (First, Middle, Maiden Surname) Emma Williams
MD 21 2 should h and Me 27 is ma imastic ev	19a. Informant's Name/Relationship (Type, Print) Martha Hamlett (Fiance) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Cranston Ave., Balto., MD 21229
Baltimore, I bernit. Pages I and Department of Healt Important: If item injury or other tra	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Degation 5 Other Specify. 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery 11/3/12 Baltimore, MD
Baltir permit. F Departme Importar	21 Signature of Funeral Service Licenses 22 Name and Address of Facility Prown Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., MD 21217
Physician /Medical Examiner	Approximate Interval failure. It is disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
	Sequentially list conditions, b
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):
to, te be executed ysician and burial - transit	d. X UNPENDED AMENDED 23a, 27, 28a-f, per me, g933 11-5-12 sm
68760, certificate be executed nding physician and ise as the burial - transi stan/Medical Ey:	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live hirth 2 Fetal death 3 Fectoric pregnancy Month Day Year
30x death re atte	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown
ords, P.O. w requires that the as been signed by t should be detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
7 6 5 14	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital hysicians this certial director	25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other:
n of ding Ph. h. After to funeral	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Division or spital or Attending rours after death. Increase Director: After filled in by the function.	2 Accident Investigation 10-25-12 fd 15:51pm 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3807 Cranston Ave.
Division of Vital Rector To the Hospital or Attending Physician: The Javinia 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page ledical Certification: To Be Com	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Replacement of the cause(s) and manner as stated.
To with To com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	Caral Allan O.C.M.E. October 26, 2012
	30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registrar	31. Date filed (Month CT Y31) 1 2012 32. Registrar's Signature 9.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Yea Bella Coster Ann 10:26 * M BOTOBER Medical 2017 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES BALTIMOTE If Under 24 Hrs. HOSPITAL Social Security Number 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours Days Min. (Month, Day, Year) Director 022-24-5593 1 🗆 M 2 🖾 F 08/08/1932 MA 80 Usual Residence of Decedent 28a-f show 10c. City, Town or Location traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits Director Catonsville MD Baltimore 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zîp Code ò 10g. Citizen of What Country? 23a Funeral USA 707 Maiden Choice Lane, Apt. 7111 21228 items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. and Mental Hygiene. 1 Never Married 2 Married δ Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: 3 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ æ Mary Mahoney Herman Couture 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Health atem 27 707 Maiden Choice Lane, Apt. 7111, Catonsville, MD John E. Coster / Husband Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any Injury or ot Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 11/03/2012 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Ceme. Westminister, MD 22. Name and Address of Facility Hubbard Funeral Home 21. Signature of Funeral Service Licensee 4107 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ IscHemic Days. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): eral Director: After this certificate has been signed by the ettending physician end filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by División of Vital Records, ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an URINARY TRACT performed? TEMPODAL RIGRATIS 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Û No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) m) CCTOBER 25, 2012

State Registrar ltimere

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 10/28/2012 8:15 A M Judith Marie Connolly Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 1 1 M 245XF <u>218-64-7022</u> 59 1/13/1953 MD permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Dejartment of Health and Mental Hyglene. Imprortent: If item 27 is manuface of other then "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes XX No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 USA 3604 Hilmar Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. 1XXNever Married 2 ☐ Married þ 1 ☐ Yes 2 ☒ No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Holy Family School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George R. Connolly, Sr. Elva Olivia Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Connolly/Mother 3604 Hilmar Rd., Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/2/2012 Sykesville, MD Lake View Mem. Park 21. Signature of Euperal Service License 22. Burrier Offer Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sarcoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or injuly that initiated events sician and burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 the use as t ettending p for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year To the Hospitel or Attending Physician: The law requires thet the within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be detachs. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1204 hat 1 ☐ Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my online. Medical 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Mille D47683 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 Raymora

DHMH 17 Rev 06-2011

State Registrar Miller

31. Dete filed (Month, Day, Year)

21117

1525

Drings

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23tate of Maryland? Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Phillip Collins 2012 1:00P Medical Oct 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6407 Kenwood Avenue Roseda1e Baltimore Co. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year) Director 212-82-8259 1 12 M 2 D F 52 June 11,1960 Maryland 10a. State 10b. County filad within 72 hours after death with the Maryland 10c. City, Town or Location r than "natural", or itema 23a or 28a-f sho the Medical Examiner must be notified at Director MD Baltimore Rosedale 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6407 Kenwood Avenue 21237 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced Specify: Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working fe. DO NOT use retired) il Hygiana. Heating Elementary/Secondary (0-12) College (1-4 or 5+) Heating/AC Mechanic Air Conditioning 12 Years permit. Paga 1 and 2 should ba filad w Department of Haalth and Mantal Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry J. Collins Margaret E. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7568 Ives Lane Dundalk, Maryland 21222 Henry Collins (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus Dundalk, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fylneyal Service Licensee Mark Williams 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due tulor as a consequence of Examiner Sequentially list conditions, It amy leading to it in recitate cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hoapital or Attanding Physician: Tha law raquiras that the daeth cartiflosta ba axacufed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physicien and completely filled in by the tunnarial director, page 2 should be datached for use as the buriar-transit Due to for as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 0 No 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1XXNatural 5 Pending 2 Accident
3 Suicide Investigation Sould not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) inpleted cause of death (Item 23a) (Type 9 31. Day filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sherrie Davis October 2012 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Patuxent River Nursing Home Laurel Prince George's Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 ☐ M 2🗶 Days Hours Min (Month, Day, Year Director 577-58-0162 66 1945 8. Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6414 Gwinnett Lane 20720 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 9 1 Never Married 2 Married 2 X No ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Davis Cecelia Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Brown/Sister 3400 Commodore Joshua Barney Dr. NE #408E Wash., 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State Riverdale Crematory 10/27/2012 Riverdale, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 21. Signature of Funeral Service Ligenses 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fails re. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer of Ovaries disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has performed? Yes 2 No death? certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 Yes 2 No 2 Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of corti 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Syed Sadiq
31. Date filed (Month, Day, Year)

14333 Laurel Bowie Road #208 Laurel, MD 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D24721

October 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1007 AM Daniel George Day Sr. 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death imore Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Months Hours (Month, Day, Year) Director 217-18-0067 1**X** M 2 □ F 88 Yrs. 11/06/1923 Virginia items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Baltimore Randallstown 1 Ves 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3809 Janbrook Road 21133 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: Black 3X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Commons Radiator Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic 7th grade Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Day Katie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel G.Day Jr. 3809 Janbrook Road Randallstown MD.21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/01/12 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. injury or 4 Donation 5 Other (Specify) Baltimore Nal't Cemetery Baltimore Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Tue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after decith.

To the Funeral Director. At completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, pleted cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar	Certificate of Death		Reg. No. 2012 34			
п	Physicia	in/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death		
~~	Medic		Peter Paul Detorie 4a. Facility Name (if not institution, give street and number)	4b Oite Terre and another of Double	October	29, 2012	11:57 PM		
	Examin	er	2519 Barrison Point Road	4b. City, Town, or Location of Death ESSEX		4c. County of Death Baltimore	2		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign		
н	Director		215–44–1817 1 X M 2 □ F 67 Yrs	Months Days Hours Min.	(Month, Day, Yo 2/28/194		rland		
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	_,,		10d. Inside City Limits		
	faryla 3a-f s tified	Funeral Director	Maryland Baltimore Essex				1 🗆 Yes 2 😾 No		
	the N or 29	٥	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?		
	n with	nera	2519 Barrison Point Road	21221	τ	J. S. A.			
	death r item iner n		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,			
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	d by	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	1 ☐ Yes 2 X No Specify:		Cassifu	nite		
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121	ed within Hygiene. other thar ent, the N	Be C		tems Analyst		Computer I	Data		
anc	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	,			
ary	should I and Me is mark		Frank Nicholas Detorie 19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rura	ivia Fran		Cadal		
Š	and 2 sh Health ar tem 27 is			19 Barrison Point R					
re,	1 and of Heg Fitem		20a. Method of Disposition 20b. Place of Di		Date 20	Oc. Location - City or To			
<u>=</u>	nit. Page 1 lartment of 1 ortant: If it injury or o		124 Delinar E C Offination o C Homovar nom otato	Valley Mem. Gard.	_11/6 _2012 5	Timonium, N	Maryland		
Baltimore, Maryland	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other ance.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		Λ.	•		
	40 = e o	S 183	23a. Part 1. Enter the disease, or complications that caused the death. Do not	Bruzdzinski Funera 1407 Old Eastern A		asex, Mary]			
١.			shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arrest,	,	Approximate Interval Between Onset and Death		
	Pnysician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Wery Disease	-		Oriset and Death		
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	Be play	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):		00001100				
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	e exec	al E	resulting in death) Last Due to (or as a consequence of):						
760	ath certificate be executed attending physician and for use as the burial-transit	edical	d						
89	ding dise as	N/L	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	en.		
30X	eath (icia	in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year		
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Records, P.O. Box 687	es that the dea signed by the a I be detached I	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the	V		
rds	requires been signal	eted			1 ∐ Yes	2 No 3 Pro			
၀၁	has by ge 2 s	Completed			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of		
č	sician: The law is certificate has t	ပိ	25. Was case referred to medical	OC Discrete Death (Obserte	performe	No 1 ☐ Yes	2 🗆 No		
Vita	ysician: T is certifica director, p	To Be	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Check		ce 6 🗆 Other (Specify	4		
of	iding Phys th. After this funeral di		27. Manner of Death 28a, Date of injury 28b, Time	of 28c. Injury at 2	28d. Describe how		2		
on	death.	fica	1 X Natural 5 □ Pending (Month, Day, Year) injur 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	y work? M 1 □ Yes 2 □ No					
Division of Vital	al or Attendi s after death I Director: A ed in by the f	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	Street and Number or Rural Route Number, wn, State)			
۵	e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. It is certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transities.		29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea	th accurred at the time, data and place an	ad also to the serve	(a) and manner as stat	ad		
	e Hos h 24 h e Fun e Fun	Medical	(Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practitioner; To the best of my knowled	vestigation, in my opinion, death occurred at	the time, date and p	place, and due to the cal	use(s) and manner stated.		
	To the within 2 To the comple	_	29b. Signature and title of certifier	29c. License number		I. Date signed (Month,	Day, Year)		
			All mg.	D 35082	0	ctober 3	18,2012		
			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		7 7177	1		
	- Chart		31. Date filed (Month, Day, Year) 32. Renietrar's Signature	Road, Balling	re, n	ND 2122	1		
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Registrar's Signature 60.	Kad					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Raymonde A. Dixon OCT. 22, 3:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3507 Springdale Avenue Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 219-28-7519 Director 1 M 2 TYF 93 Jan. 4/1919 France Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 USA 3507 Springdale Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' 1 Never Married 2 Married Completed by Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 🖁 Widowed 4 🗆 Divorced If Yes, Give Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Should be filed with h and Mental Hygien. 7 is marked other th School System Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 E. Fayette Street 6th Floor Baltimore, MD 21212 Freida Jones - Guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Holy Rosary Cem. 1 Burial 2 Cremation 3 Removal from State 10-29-2012 Baltimore MD 4 Donation 5 Other (Specify) Signature of Funeral Service Leonard J. Ruck, Inc. 5305 Harford Road Ba Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ alblobe disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to jor as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Exam and I-tran Due to (or as a consequence of) resulting in death) Last the attending physician a shed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 No After this certificate funeral director, page 1 ☐ Yes 2 🔏 No 25. Was case referred to medical 26. Place of Death (Check only one) Be A55.5666 Hospital Other: 2 🗓 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 🔀 Natural 5 Pending injury n 24 hours after death.

e Funeral Director: After objectly filled in by the fun Acciden Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of pe

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Belversere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Sylvia 30, 2012 Alice Davis 1:01 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1829 Middleborough Road Essex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Director 215–30–5882 Usual Residence of Decede 1 M 2 X F 6/20/1934 78 Pennsylvania 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 🗆 Yes 🌉 No Maryland Baltimore Essex 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner must** 1829 Middleborough Road United States 21221 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force or i Black White etc. ò 1 Never Married 2 Married 1 Yes 2 XNo within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: 3 ♥ Widowed 4 □ Divorced Completed white Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Baltimore County School System Elementary/Secondary (0-12) College (1-4 or 5+) event, the 12 Guidance Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ Archibald Keiper Sylvanus Catherine Agnes Demkovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1829 Middleborough Road Essex Maryland 21221 27 Glenn Davis (son) item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 11/02/2012 BelAir Maryland 4 🗍 Donation 5 🗌 Other (Specify) Belair Mem Gardens Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Adenocarcino ma disease or condition resulting in death) age months Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or injury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed certificate 1 Tyes Yes 2 Be 25. Was case referred to dical the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify this 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director; A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signaty

Registrar DHMH 17 Rev 06-2011

State

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SUITE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29c. License number

Philadelphia

od Battino

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:50 am october 27, 2012 Devers **Blanche** Shellev 5 1 1 2 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Parkville Oak Crest 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Davs Hours 83 19<u>29</u> 220-20-4996 Director Feb_ Mary land Usual Residence of Decedent 28a-f show the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 U.S.A. 8810 Walther Blvd., # 1505 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 XXNo Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give 1 Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Devers Shelley Clara William Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Constantine Dr., Phoenix, MD 21131 29 Constantine Dr., Phoenix, Robert H. Dyer, Sr.-friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If in any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clynmalira UMC Monkton, MD 21. Signature of Fugeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, holange o carcunomo disease or condition resulting in death) Medical Due to (or as a co sequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. ites Onderlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown P.O. á Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed' this certificate 1 Yes 2 No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature a

title of certifier

aux mon ompleted cause of death (Item 23a) (Type, Print)

mson 8800 Walthor

29c. License number

Blid Parkville NO 21234

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G933, 11/272012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 34646 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24, 2012 Year Donald William Dorman 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8 Valiant Drive Abingdon Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Min. Hours (Month, Day, Year) Director 221-26-2540 1 ☒ M 2 ☐ F 75 1936 Nov. 14, Delaware Usual Residence of Decede in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits irector Maryland Harford Abingdon 1 Yes 2 X No Ճ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 8 Valiant Drive 21009 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Salesman Automotive other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file the end Mental H ၉ permit. Pege 1 and 2 should be Department of Health end Meni Important: If item 27 is marke any injury or other treumatic. Alice Lina Beauchamp William Carey Dorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen G. Dorman / Wife 8 Valiant Drive, Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-27-12 Bel Air, Maryland Air Memorial Gdn. ure ph Funeral Service V 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21. Sly Mom co 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between PICK'S DISEASE Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Due to (or as a consequence of):

INFUTTON TERMINAL Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CEREBRO VISCULAR ACCIDENT sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FFMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year ed by the a 2 🗌 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has t een sign age 2 should be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.20 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, ago 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Nesidence} \) Residence 6 \(\text{Other} \) Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year)

OCTO BJER 25 2012 29b. Signatu th (Item 23g) (Type Print) 716 HARPOND RL SU. 155 FAMSTO 30. Name and addr ECTO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	arylan					nd M	ental Hy	giene	201	2	34647
			Registrar 1. Decedent's Name (First, M	iddle I as	21		Cen	tificate	of De	eath		0.0-1(0	Reg. No.	201	4	
	Physicia		LEON		ANLEY		DOCHI	NGER				2. Date of De Month OCTOBE		2012 Year	r	3. Time of Death 12:20P M
	Medic Examin		4a. Facility Name (if not institu				Doom	4b. City, To	wn, or L	ocation of	Death	OGIODE		County of D		12.201
1			ROLAND PARK					BALT						N/A		
	Funeral Director		5. Social Security Number 145-14-4902	6. S	ex 7. Ag X] M 2 □ F	je (In yrs. la	ast birthday)	If Under 1 Months [Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da			Birthpla Country	ace (State or Foreign
			Usual Residence of Decede	nt	AIMZUF		88 Yrs.					08/30	/192	4		NJ
1	f sho	tor	10a. State 10b. Co	,		10c. City	y, Town or Loc	ation						-	10	d. Inside City Limits
	r 28a notifi	Director	MD N. 10e. Street and Number	/A		BA	LTIMOR									1 X Yes 2 □ No
4	23a o st be	ıral	830 WEST 40	רט נוי	יסקקיי #50	/1		10f. Zip C					10g. Citi	zen of What	Countr	y?
4	tems er mu	Funeral	11. Marital Status	.11 01	12. Was Decedent	Ever in U.S		/as Deceden	nt of Hisr	panic Origin	n? (Spec	ify Yes or No-		14. Race - A	nerica	ı İndian,
၀ ်	", or i	b	1 Never Married 2		Armed Forces? 1 X Yes 2 □ If Yes, Give			Yes, specify Yes 2			Puerto H	lican, etc.)		Black, W		
0500-61	atural cal Ex	Completed	3 X Widowed 4 ☐ Divo	rced edent's E	Year or Dates.			ent's Usual C						Specify: W		
ה ל ה	an "n Medi	ldm		nighest gra	College (1-4 or	5.+1	(Give k	ind of work of NOT use re	done dui		of workin	g	16b, Kii	nd of Busine	ss/Indu	istry
V	ygiene ygiene her th ht, the				5-			PLAN	NT P	ATHOL	OGY			ENV]	RON	MENTAL
yland	ntal H red ot	To Be	17. Father's Name (First, Midd SOL	fle, Last)			DOCUEN	OED.	1			(First, Middle,	Maiden S		CDM	A 37
	mark mark		19a. Informant's Name/Relat	onship (T	/pe. Print)		DOCHING		Street an	DIAN		Route Numbe	r City or		ERM.	
ב ב ב	Health a tem 27 is		BETH DOCHING	ER/D	AUGHTER			-				CINCIN			,	,
parumore,	perfilt. Tage I and 2 should be insert within 72 hours aren death with the waryland perfilt. Tage I and 2 should be insert within 12 hours are the perfect of Health and Mantal Hypert than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Crema	tion 3 🛛	Removal from State	20b. P	lace of Dispos emetery, crem	ition (Name	of			ate		cation - City		
	t. rag tment tant: jury o		4 Donation 5 Oth	er (Specif	y) A	WE	LLWOOD	CEMET	ΓERY	_ 10		/2012		INELAW		
09	Depar Impor any ir		21. Sign Jure of Funeral Serv	ice Licers	11100							LEVINS				
			23a. Part 1. Enter the diseas	e, or com	olications that caused	d the death								SVILLE		ID 21208 Approximate
Pi	yucian/	es M	23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in e. Immediate Cause (Final disease or condition AVICUSONS ASSOCIATED ASSOCI													
4	Medical xaminer		resulting in death)		a. Due to (or as					100					1	
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									+				
pat	ansit	amin	Cause, Enter Underlying Cause (Disease or injury													
PXPCI	an and irial-tr	dical Examiner	that initiated events resulting in death) Last		Due to (or as	a consequ	ence of):									
3 4	physician and the burial-transit	dica			d										+	
	nding p	J/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome	of pregnar	ncy							20.1 D-11	4 - 15	
death c	e atter	Physician/M	in the past 12 months? 1 Yes 2 No		1 Live Birth 4 Pregnant a	2 🗌 Feta It time of d		Ectopic predother (special						23d. Date of Month		v ay Year
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r the	signed I be d		Part II. Other significant con		ontributing to death t	out not resu	ulting in the ur	iderlying cau	ise giver	n in Part I.						cause of death?
e law requires	been	letec	nnum	1100	A							24a. Was				v findings available
	e has	Completed by	Trices.		- 41							autor perfo	rmed?	prior t death	o com	pletion of cause of
/ Itali F	rtifica ctor, p		25. Was case referred to med examiner?	ical [26. Plac	e of Death	(Check	1 \(\text{Yes}\)	2 No	1 1 1	res 2	□ No
hvsic	this ce	은	1 Yes 2 No				ER/Outpatient	3 🗌 DOA	Other:	4 Wurs	ing Hon	ne 5 🗆 Resid	dence 6	Other (Sp	ecify)	
	h. After funer	Certificate:	27. Manner of Death 1 Natural 5 Pe		28a. Date of inju (Month, Da		28b. Time of injury	28c.	. Injury a work?	at es 2⊡N		8d. Describe h	ow injury	occurred		
VISIOII Pr Affendin	ector: by the	rtifi	3 Suicide 6 Co	estigation ould not be termined	28e. Place of Inju					25 Z L IN		8f. Location (9	Street and	Number or i	Rural Fi	oute Number,
בַּ בַּ	al Dir		Duilding, etc. (Specify) City or Town, State)													
dsoH	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 <u></u> Medic	al Exami	sician: To the best of ner: On the basis of e	xamination	and/or investi-	gation, in my	opinion,	death occu	urred at t	he time, date a	nd place.	and due to th	e caus	e(s) and manner stated.
To the	within Fo the	Σ	only one) 3 ☐ Certif 29b. Signature and title of cer		e Practitioner: To th	e best of m	ny knowledge, o		ed at the icense n		and plac	Ti Ti		s) and manne e signed (Mo		
			> fleerly,	Dr	abla 0			D	35	102				UBER		
			30. Name and address of per-	Maria .		_	23a) (Type, Pr					Freet	1		W	1001/200
	Stat		31. Date filed (Month, Day, Yes	OY)	M.D. 5	901 ar's Signati		~Ih	<u> </u>	AVL	5 /	treel	リオト	mon	4.1	HANTIMAN
	Registra		OCT 3 0	2012	and.	A	had									
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kevin Michael Ellis 28 2012 7:40a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore N/AIf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 215-82-6073 Director 1 □XM 2 □ F 52 Yrs 09/02/1960 MD should be filed within 72 nouse con-end Mentel Hygiene. I be merked other then "naturel", or Items 23e or 28e-f ehow manimetic event, the Madical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 5604 Northwood Dr. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Masonary Const. Co. Construction Worker 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Calvin Ellis Clementine Mosby permit. Page 1 and 2 should be Department of Heelth end Ment Importent: If Item 27 Ie merke eny Injury or other traumetlo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette M. Ellis (Wife) 5604 Northwood Dr. Baltimore, MD 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State 11/6/12 Baltimore,MD 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory 21. Signature of Foneral Service Lic-Joseph H. Brown Jr. 2140 N. Fulton Ave. Funeral Home PA Balto., MD 21217 Part 1. Enter the disease, or complidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heap failure. List only one cause on each line. Approximate Interval Between C11/05 W Immediate Cause (Final Onset and Death Physician/ per disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OGSMUCTUR urs Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hoepitel or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director: Dead 2 should ha detached to the funeral director. Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 XN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

3

DHMH 17 Rev 06-2011

Registrar

1201

6701

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28 20^{Year}2 OCTOBER 11:00AM Madge Frazier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days (Month. Dav. Year) 215-12-3086 Director 90 1 M 2 X F May 25. 1922 Virginia permission of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 1 No Stewartstown Pennsylvania York 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17363 USA 18278 Hrebik Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4 or 5+) Mathmatician Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nina Reid Don L. Sheetz FRAZIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18278 Hrebik Road Stewartstown, Pennsylvania 17363 Robin Kenealy/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or conce. 1 Burial 2 The Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc.: 10/28/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. Custer tephanie 21. Signa e of Funeral Service Lie 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy r this certificate haral director, page 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) မှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. • Funeral Director: After this letely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the P only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20c per fh 932 10-31-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBEY Year ivian 5.45PM Bell Fuldhar 2012 Medical 4a. Facilify Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Care Future ochear If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 29.40.1092 1 □ M 2 🔽 F Months Hours Day Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the M dical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Saltin 1 Yes 2 No nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 10 Tomber (burt USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Completed by 1 Yes 2 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade rebt Collector Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hazel Jones Sadie Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Fulahan Baltimore Court .Husband) MD Tomber 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 11100 4 Donation 5 Other (Specify) Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility . Greene Funeral sarvices Vaughn Road Handallstown M.D. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical o (or as a consequence of) Examiner Obstruc Disease Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Chron the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No cate has been signed by the a page 2 should be detached a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Diabete Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 4 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) edical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D 31464 MD 3111 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUTAW ST fint. 308 BACTIMOREMD 21261 HASEMI MD 821N. 31. Date filed (Month, Day, Year) OCT 3 1 State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 23, 2012 5:54 Harriett Lorraine Fields October /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Holly Hill Nursing Home Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F 1933 Maryland Aug. 27, 217-28-8864 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA. 21085 900 Joppa Farm Road by Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 27 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Cashier 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella (unk) Kocay Harry (nmn) Hobell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael A. Gray / Son 3171 Old York Road, White Hall, MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs, LLC 10-26-2012 Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 5 □ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day ☐Yes 2 No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy after death.

| Director: After this certificate | 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 44 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide within 24 hours a To the Funeral D Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 3508 BANKST LIBERTU 32. Registrar's Signature 31. Date filed (Month, Day, Year)
OCT 3 1 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland				and M	lental Hy	giene	•		01 (52
			Registrar 1. Decedent's Name (First, Middle, L.	ast)		Cer	tificate of	Death		2. Date of De	Reg. No	<u>2U</u>	12	34652
	Physicia Medic		David	Falck	V					Cetob		24 2	Year 012	3. Time of Death $5.03 PM$
	Examir		4a. Facility Name (if not institution, given thwest t	e street and number)			4b. City, Town, o	2			40	. County o		ODE
	Funeral		Social Security Number 6.	Sex 7. Age	In yrs. las	st birthday)	If Under 1 Year Months Days			8. Date of Bir (Month, Da		BA		lace (State or Foreign
	Director		214-16-9266 Usual Residence of Decedent	1 X] M 2 □ F	93	Yrs.	Months	riouis	IVIIII.	06/30		9	Count	MD
	yland f show ed at	ξį	10a. State 10b. County		10c. City,	Town or Loc	ation						10	0d. Inside City Limits
	or 28a- notifie	Director	MD BALT 10e. Street and Number	IMORE	ВА	ALTIMO	RE 10f. Zip Code				10 - 0	itizen of W		1 🗆 Yes 2 🔀 No
	s 23a o	Funeral	2 POMONA EAST,	#209			212	:08			10g. C1	US		ıy.
	r death ir item iner m		11. Marital Status 1 ☐ Never Married 2 ※ Married	12. Was Decedent Event Forces? 1 ☑ Yes 2 ☐ N	er in U.S.	13. V	Vas Decedent of F Yes, specify Cub	lispanic Or an, Mexica	rigin? (Spec in, Puerto F	cify Yes or No- Rican, etc.)		14. Race Black	- America	
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ed by	3 Widowed 4 Divorced	1 ♠ Yes 2 ☐ N If Yes, Give Year or Dates.	0	1	☐ Yes 2X No	Specify	<i>/</i> :			Specify:	WHI	
15-(i filed within 72 hour tal Hygiene. ta other than "natu event, the Medical	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give k	ent's Usual Occur ind of work done	during mos	st of workin	g	16b. K	Kind of Bus	siness/Ind	ustry
212	within giene. er thar		Elementary/Secondary (0-12)	College (1-4 or 5+)		SAL	NOT use retired) ES]	FURNI	TURE	
and		To Be	17. Father's Name (First, Middle, Last,							(First, Middle,	Maiden	Surname)		
aryli	should be fi and Mental Is marked aumatic ev	ľ	BENJAMIN 19a. Informant's Name/Relationship (ALCK	19b. Mailin	g Address (Street		NNIE er or Bural	Route Numbe	er. City or	r Town. Sta		OLDBERG odel
Σ,	2 ⊞ Z		MATILDA FALCK/W	LFE			ONA EAST				-		1208	
nore	Page 1 and ment of Hea ant: If item ury or other		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	cer	metery, crem	sition (Name of atory or other place			ate		ocation - C	-	
Baltimore, Maryland	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Spec		BETH		Name and Addre					ALTIM & BRO		
8	Pe a T Pe		Cet	3		8	900 REIS	TERST	COWN 1	ROAD, I	PIKES			
	hysician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	ne death.	Do not ente	r the mode of dyir	ig, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death
-	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a c	onseque	nce of:	11.11						10	nknown
		er	Sequentially list conditions,	b. HECT	al	flb.	vilati	on					- 4	unknown
	uted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Polye	est	hen	ria V	era						unknowi
_	be executed sician and burial-transit	dical Ex	resulting in death) Last	Due to (or as a c	Inseque	nce of): ! ed	fusio	ne						Inknown
3760	ficate k g phys as the	/ledic		d	vac	H	Juse 01			_	_			////C/////////////////////////////////
Box 687	death certificate be executed the attending physician and ed for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal of	death 3 🗌	Ectopic pregnance	су				23d. Date		*
B	the dea by the a ached f	hysic	1 Yes 2 No 9 Unknown	4 Pregnant at ti 9 Unknown	me of de	ath 5 □	Other (specify) _					Mont	ın ı	Day Year
P.O.	ss that the dea igned by the a be detached f	by	Part II. Other significant conditions	contributing to death but	not result	ting in the ur	derlying cause gi	ven in Part	1.					cause of death?
rds	require been si should	eted										7		ably 4 Unknown
Records,	he law te has	Completed									psy prmed?	pri de	ior to com ath?	sy findings available pletion of cause of
talF	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?						th (Check		2 🔀 No	0 1	☐ Yes 2	! □ No
of Vi	r this ceral dir	e: 10	1 ☐ Yes 2 🗷 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury		R/Outpatient 8b. Time of	3 DOA Oth	4 ∐ N		ne 5 🗆 Resid				
on (ending eath. or; Afte the fun	Certificate:	1 № Natural 5 ☐ Pending 2 ☐ Accident Investigation		(ear)	injury	work			od. Describe i	iow injury	y occurred		
Division of Vital	or Att after d Direct	Certi	3 Suicide 6 Could not 4 Homicide determined			e, farm, stre	et, factory, office		2	8f. Location (S City or Tow			or Rural F	Route Number,
Ω	the Hospital or Attending Physician: The law requires that the that A hours after death, the Funeral Director. After this certificate has been signed by the appletely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Phy	vsician: To the best of my	knowled	lge, death o	ocurred at the time	e, date and	place, and	due to the ca	ause(s) a	nd manner	r as stated	d.
	To the Hosp within 24 ho To the Fune completely f	Me	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nui 29b. Signature and title of certifier	niner: On the basis of example of the basis	est of my	knowledge,	death occurred at t	he time, da	ccurred at t	ne time, date a e, and due to t	he cause	(s) and due to	nner as st	ated.
	o o o wit		► AGramat	ikova, M.	D		290. License	728	310		Oct.	te signed (ivionin, Di 24,	2012
<i>Y</i>			30. Name and address of person who			3a) (Type, Pr	int) 171_1	0	10			-1	11	ase(s) and manner stated. ated. ay, Year) 2012
	Stat	e	31. Date filed (Month, Day, Year)	32. Pegistrar's		040	11 VIX	Loue	TKO	ia, Kai	nalls	STOWA	2, M	uylana 1133
	Registra	ır	OCT 3 0 2	112 Duna		pa	Kel							

DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 1107 A M Month Physician/) or other Freeman 26 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Levindale Geriatric Center N/AIf Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NJ Social Security Number 8. Date of Birth **Funeral** Months Days 1 M 2 X F Hours 0671671914 099-05-5321 98 **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 ☐ No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2434 W. BELVEDERE AVENUE 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes Give Completed 3 Widowed 4 N Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Media Elementary/Seconday (0-12) College (1-4 or 5+) 12 MANUFACTURING Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMUEL LEVY IDA LAZAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10203 OAKTON STATION COURT, OAKTON, VA 22124 ROSLYN SAMUELSON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 □ Cremation 3 🕅 Removal from State 4 □ Donation 5 □ Other (Specify) 10/28/2012 ELMONT, NY BETH DAVID 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STRUCK disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) rsician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day ed by the a detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available 24a, Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No 2 X N **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 XNo 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Cle Hamouse CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Ele Ha Morse, 2434 W. Be lucture Auc,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ner State of Maryland / Department of 1-For State Certificate of Registrar		ygiene Reg.	2012 3	+65				
Physici al Exami		1. Decedent's Name (First, Middle,Last) Denise Andre Gardner		2. Date of Death Month D October 27,	3. Time of D 2012 0353 h					
		4a. Facility Name (if not institution, give street and number) 315 Lennox Avenue	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore County					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 - 70 - 2224 1 M 2 F 55 Yrs	If Under 1 Year If Under 24Hrs, Months Days Hours Min. Months Days Hours Min.	_ `	MM/DD/YYYY) 9. Birthplace (State Foreign Country) M	aryl				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside (City Limits				
*	tor	MD Baltimore Towson	Lector		1 Yes	2 X No				
the Mary a or 28a tiffed at	Director	10e. Street and Number 315 B Lennox Avenue	10f. Zip Code 21 286		Citizen of What Country?					
12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 2. It marked inter than "natural", or items 23a or 28a-f shoumatic event, the Medical Examiner must be notified at once, unmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	as Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Bi White, etc.	lack,				
hours afte "natural", Examiner	-		Yes 2 No specify: nt's Usual Occupation (Give kind of woost of working life. DO NOT use retir		Specify: Black 6b. Kind of Business/Industry	· -				
permit. Pages 1 and 2 should be filed within 72 hours af pepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural injury nr other traumatic event, the <u>Medical Examin</u>	Completed		mployed	(First, Middle, Mai	N/A					
d be filed fental Hy narked nt event, the	Be C		Audr g Address (Street and Number or R		,					
th and N 27 is m umatic	To		B Lennox Ave.							
Pages I and nent of Heali nnt: If item or other tra		1 Burial 2 Cremation 3 Removal from State crematory or of	her place)			-				
permit. Pa Departmer Importan Injury nr		21. Signature of Funeral Service Licensee 22.	Crematory 11 Name and Address of Facility natman-Harris		Dunda _{lk, Md} to. MD 21215					
ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	natman—Harris he mode of dying, such as cardiac or	F.H 524 respiratory arrest,	O Reisterstow shock, or heart Approximat Between O	te Interval				
scuted and transit	Examiner	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): b. Due to (or as a consequence of): C. Due to (or as a consequence of):								
e be execu ysician an burial - tr	edical	■ MENDED 23a,27,28a-f,p	er me,g934 12-3-1	l2 sm						
eath certificat attending phy for use as the	sician/M	past 12 months?	ntal death 3 Ectopic pregnar her (Specify)	ncy	23d. Date of delivery Month Day	Year				
ires that the d signed by the I be detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	-	cco use contribute to the cause of d					
he law requir ate has been s age 2 should I	Completed			24a. Was an autopsy performe		cause of				
certificate rector, page	å	25. Was case referred to medical examiner? Hospital: Innation: 2 ER/Quitostient	26.Place of Death (Check o		19320					
ing Physical After this uneral direction	유	O 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Wising Home 5 Residence 6 Other								
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To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed (Specify) Other residence		28f. Location (Stre or Town, State Towson, M	et and Number or Rural Route Num a) 319 Lennox Ave. b.	nber, City				
To the Hos within 24 h To the Fun completely	g	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigal								
T W	Medi	29b. Signature and title of certifier Pamelo Withaell, Mi	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year) October 27, 2012					
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900) W. Baltimore Street, Baltin	nore, MD 2122	23					
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ anne Medical **Examiner** 4a. Facility Name (if not institution, give street and 4b. City, Town, or Location of Death County of Death (51 0 THIP 101 0 **Funeral** If Under 1 Year Birthplace (State or Foreign Country) Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Months Hours Director 92 4966 461 1 M 2 X F 63 12 29 1948 Texas or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8267 Camion Court 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Grady Stevens Thelma Ruth Rorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Gawne - Husband Pasadena, MD 8267 Camion Ct. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cem 10/26/12 Crownsville, MD Signature of Funeral S ce Licensee GJ Gonce Funeral Home, P. 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician OC av disease or condition Medical resulting in death) Examiner onar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day ed by the at detached for 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has I tuneral director, page 2 autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Tes 1 Inpatient 2 R/Outpatient Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ce 29d. Date signed (Month. Day, Year, State 3 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER Robert Edward Howe 9:32 2012 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death St. AGNES 108PITAL BALTIMORE n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Month, Day, Year) 1929 New York Hours 099-22-4064 Director 83 1 X M 2 □ F May Yrs Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the World Franciner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 715 Maiden Choice Lane, Parkview 601 12. Was Decedent Ever in U.S.
Armed Forces? 1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1954 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hyglene. Item 27 is marked other than " American Can Company Elementary/Secondary (0-12) College (1-4 or 5+) Sales Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Harrell Howe Edith Pearl Dickinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kit Howe Peres/daughter 2312 Poplar Drive Gwynn Oak, Maryland 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/27/2012 Baltimore, maryland 21. Sun ure of Euneral Service License Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, inc 299 Frederick Road Baltimore, maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysiciani PNEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner HOURS Severe SEPSIS Sequentially list conditions, if any, leading to immediate couse Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Pnysicians are two completely the attending physician end within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical OX/E KOKE Let Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown 24a. Was an 24b. Were autopsy findings available prior to completion of death? autopsy performed* 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မှ 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25 2012 OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print S. CATOH AUE BALTIMORE 31. Date filed (Month Day, Year) 32. Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James R. Heath Sr. October 27 8012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinci Hospital
Social Security Number 6. Sex 06 Bultimore Baltimore, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Birthplace (State or Foreign Country) Days Hours (Month, Day, Year 73 Director 216-36-4633 4-10-1939 MD Usual Residence of Deced show ir than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Lochearn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 USA 6229 Robin Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 2 1 Never Married 2 XMarried Maryland 21215-0036 African-American 1 ☐ Yes 2 No Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. ?7 is marked other than "' Elementary/Secondary (0-12) College (1-4 or 5+) Laborer **Fabricator** Company permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked othe any injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Heath Julia Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6229 Robin Hill Rd., Lochearn, MD 21207 Margaret L. Heath/ Wife Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-7-2012 Garrison Forest Veterans Owings Mills, MD 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death S Immediate Cause (Final - Pnysician Consestive Floor + Failure
Due to (or as a consequence of): disease or condition MUDOUN Medical resulting in death) Examiner In Knows Coronary Arter. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a const uence of): burial-tran that initiated events 2 Due to (or as a consequence of): resulting in death) Last the attending physician ched for use as the buria Physician/Medical Patient Knaun certificete be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Completed by Records, Acute on Chronic Renal Failue 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anomica of Chronic Disecso has autopsy performed' this certificate 1 ☐ Yes 2 ☐ NO Yes 2 N Division of Vital the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{\text{Nursing Home}} \) 5 \(\text{\text{Residence}} \) 6 \(\text{\text{Other}} \) Other (Specify) 1 Yes 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Prostcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 170074715 October. 27 2012 10x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Since Hoopital af Baltimore JOSHIUM BIRNIBA CIM UM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 3 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ Otis Hopkins Jr. 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth n 8006 176 **Funeral** Year) Days Months Hours **Director** 218-60-2837 1 □ M 2 🏻 F 58 11/05/1953 N.Carolina Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Examiner must be notified at Director Baltimore 1X Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 21217 USA 210 North Carey Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. o, þ 1 Never Married 2 Married Maryland 21215-0036 nan "natural", If Yes, Give Year or Dates 1 Yes 2X No Specify: SpecifyBlack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " vent, the Med Elementary/Secondary (0-12) College (1-4 or 5+) GAF Machinist 9th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) and Mental I Pearlean Coppage Otis Hopkins Sr. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other traus. 306 Arthur Ave. Port Deposit, Maryland 21904 Princess Hopkins Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place 11/1/12 |Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4210 Belair Road Rd Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Tyocard 20102 disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Die to (or as al nonsequence on: burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): /sician Physician/Medical ding phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 des 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 \square No Yes 2 completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1. Natural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner To the best of my his whole. Seath occurred at the time, date and cleane and cleane and cleane and cleane and cleane and cleane and cleane. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number October 25 500 Upper Chesa on who completed cause of death tern 23a) (Type, Print) SON 32. Registra 's Signa 2012 31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Evie L. Hnatiuk 11:46 PM 2012 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4128 Beachwood Road Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director 1 🗆 M 2 😾 F 212-42-0997 9-5-1943 69 ΔV permit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show eny injury or other traumatic event, the Medicul Exercities must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 4128 Beachwood Road 21222 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Fork Lift Operator Continental Can Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Walter Hicks Dorothy Sprouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Hnatiuk Husband 4128 Beachwood Road Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 10-29-2012 4 Donation 5 ☐ Other (Specify) Middle River, MD 21. Signature of Funeral Service Cigure ²² Name and Address of Facility
Connelly Funeral of Dundalk, PA
7110 Sollers Point Road Dundalk, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death , or heart failure. List only one cause on each line Immediate Cause (Final disease or condition of surling Physician Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate ba executed Cause (Disease or injury that initiated events resulting in death) Last tha attanding physician and thed for usa as tha burlal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year cate has baen signad by tha page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 24 hours after death. Funeral Director: After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No the Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fi 29a, Certifie 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who comple

31. Date filed (Month, Day, Year)

8600 Usalle ROSD POTOMOR BLIS

cause of death (Item 23a) (Type, Print)

MD

. Registrar's Signa

Please Type or Print in Black Indelible Ink./Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 2 34660 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 11:36 AM 2012 Marguerite Katherine Hall Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 232<u>1-321535</u>0 **Funeral** (Month, Day, Year) Director 52 4646 1 □ M 2 🔀 F 93 6, 1918 Kansas Usual Residence of Decedent and Martal Hygiene.
is marked other than "natural", or items 23a or 28a-f show
is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Harford Maryland Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21160 4131 Little Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Public Education School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ Mall Margaret L. Riley (unk) Coltharp other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tran Donald R. Hall / Son 4131 Little Road, Whiteford, MD 21160 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 70D cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs. LLC 10-29-12 Bel Air, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingd.

23a. Pat 1. Enter the disease, or complicating shock, or heart failure. List only one carbise on each line. 21/97 Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Severe disease or condition 0 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hall, margueri Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day the a 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 24 No INAR 1 Yes 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral Director. After this certificate has the funeral director, page 2.3 autopsy death?
1 Yes 2 No maco 106396 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1/2 Natural iniury 5 \square Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Fractitioner: To the cause of a place with creaming at the time, date and class and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053568 October 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 LIPPUT resaperte 31. Date filed (Month HOLPSON 32. Regi 21047 31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 8:35PM John M. Haire October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months (Month, Day, Year) Country) Director 246-32-5082 Usual Residence of Decedent 1 X M 2 □ F Yrs 84 December 13, 1927 North Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other treumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 611 Linthicum Street 20851 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates. WWTT White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Financial Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest F. Haire Mabel Morrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Linthicum Street, Rockville, Maryland 20851 Marjorie S. Haire/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State October 31, 2012 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Left Sided Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death Least Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the at Id be detached for Pregnant at time of death Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires Atrial Fibrillation Completed 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown been signal 24a. Was an Were autopsy findings available prior to completion of cause of Hypertension page 2 s has autopsy performe certificate Cerebral Vascular Accident Yes 2 N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director; Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner. On the basis of examination a law involved and place, and due to the cause(s) and manner as stated.

Zertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855 Debrah Miller, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 3 U 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 04:44P M 2012 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4730 ATRIUM COURT, BALTIMORE OWINGS MILLS Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Min. Director 216-20-7314 1 X M 2 - F 84 MD 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 X No MD BALTIMORE OWINGS MILLS 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21117 4730 ATRIUM COURT, #250 USA 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No
If Yes, Give 0 1 Never Married 2 X Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be f 2 LOUIS ISAAC RAE MENDELSON . Page 1 and 2 should tment of Health and M **tant: If item 27 is ma** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13412 ALLNUTT LANE, HIGHLAND, STEVEN ISAAC/SON MD 20777 20b. Place of Disposition (Name of caractery, cramatory of atternation CEMETERY CHIZUK AMUNO CONG. Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ö Department of Important: If any injury or 4 Donation 5 Other (Specify) BALTIMORE, MD turn of Funeral Service Incen-22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complication Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 009 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No' 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) the 9 Unknown q Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PArkinson's Diense 1 Tes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Do 24a. Was an autopsy After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending n 24 hours after death.

e Funeral Director: Af eletely filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou

To the Fune

completely fi

State Registrar (Check

29b. Signature and title of certified

30. Name and address of person who con

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Procitioner: To the best of physical knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7801 York Rd # 300 Tousan MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4:08 PM Physician/ MICHAEL C. JONES /0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Roseda Franklin uare 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs Funeral Days Hours Director 85 217-22-9188 1 X M 2 - F July 31,1927 MD. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at. 10b. Count Director 1 Yes 2 X No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21236 4416 Ebenezer Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces? 1 Never Married 2 Married Completed by White Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. WW11 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Navistar 12 vrs Salesman N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie A. Hoffman George F. Jones, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Arm, Md. 21057 15 Tree Farm Ct. Linda D. Salihi (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 11-3-2012 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛂 No |요 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) P.M. selle 10 29 2012

State

Jones

DHMH 17 Rev 06-2011

Registrar

30. Name arru DS . ST (LOST V 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square Drive Baltimure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ Veola Jackson 1 9 2012 11:00рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5724 Northwood Drive Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Days 212-58-7221 Director 1 □ M 2 🗓 F Yrs. 3-8-1951 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23s or 28s-f shov treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours efter deeth with the Meryland Director Maryland 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21212 5724 Northwood Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 호 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21K No Specify. Specify:Black 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry permit. Pege 1 and 2 should be filed within 72 i
Department of Heelth and Mentel Hyglene.
Important: If Item 27 is marked other than "n.
any injury or other freumetic event, the Mentel
once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S.Postal Service Sorter years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည George Jackson Leona H.Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5724 Northwood Dr.Baltimore, Maryland 21212 Kelley D.Jackson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Maryland Woodlawn Cemetery 10/27/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses ller Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DIOMOLL disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami ours after death. Iersal Director: After this certificate has been signed by the attending physicien and filled in by the funerel director, pege 2 should be deteched for use es the burlel-trensit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physiclan/Medica! Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 \ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospitsi o within 24 hours at To the Funeral D completely filled Medical 29a. Certifier 1 Secrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 560 a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34665 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:40 AM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Baltimore N/A 6. Sex . Age (In yrs. last birthday, Year If Under: 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month. Dav. Year) 219-26-1999 **Director** 1 □ M 2🌠 F 75 Yrs. 07/16/1937 MD 28a-f show and 2 should be filed within 72 hours after death with the twarynems. Health and Mental Hygiene. Items 27 is marked other than "natural", or items 23a or 28a-f shon other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location State 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Millington Ave. 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes. Give 3 XWidowed 4 ☐ Divorced Specify: Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) to date Laundry Elementary/Secondary (0-12) College (1-4 or 5+) Laundry 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John H. Hughes Ivory Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Hughes 4104 Mariban Ct. Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Date / 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 10/29/12 On-Site Crematory Baltimore, MD ^{22 N}Josephs H. Brown Jr. 2140 N. Fulton Ave. Signature Home PA MD 21217 Funeral Balto., MD part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or wearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTICEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? □ Ectopic pregnancy Month Day 1 Yes 2 9 Unknown Pregnant at time of death Other (specify) Year g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performe 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 KNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 26 2012

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

OCT 31

5+.

Greek

21201

Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ DAVID ALLAIN JOHNSON 10 Medical 4a. Facility Name (if not institution, give street and number)

GOOD SAM ARITAN HOSPITAL 4b. City, Town, or Location of Death
BALTIMORE (MD) 4c. County of Death **Examiner** N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days 253-68-0179 1 ፟M 2 □ F Director MAR. 11 1943 MARYLAND 69 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. Count Director 1 ☐ Yes 2 🕅 No ESSEX BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21221 1600 EVERGREEN WAY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 호 1 ☐ Yes 2 K No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 60/63 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) PATAPSCO RAILROAD CLERK 12y<u>rs</u> Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BEATRICE COOSENBERG DAVID JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Evergreen Way, Essex, Md., 21221 Beulah M. Smith Johnson/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11-05-12 OWINGS MILLS, MD. 4 Donation 5 Other (Specify) GARRISON FOREST 21. Signature of Fun 1 Style Ligens 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOGENIL Physician Medical resulting in death) OCARDIAL IN FARCTION Examiner RECURRENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ORON AR Hosgital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown To the Hospital or Attending Physician: The law requires unat une within 24 hours after death.

To the Funeral Director: After this certificate has been signed by I completely filled in by the funeral director, page 2 should be detacled. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Brama 29c. License number 29d. Date signed (Month, Day, Year) RES 25-2012 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ABRISHER SHARMA, 5601 LOCH ROVEN BIVD, BALTIMORE, MD 21239 31. Date filed (Month, Day, Year) 37. Registrar's Signature OCT 3 1 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 23:36 M Physician/ 2012 Medical 4b. City, Town, of Location of Death 4c. County of Death Facility Name (if not institution, give street and number) Examiner HOSPITA 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days July 1, 1942 Hours Min Pennsylvania 70 215-42-7938 Director 1 □ M 2 🂢 F Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location Director 1 Yes 2 No Overlea Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21206 437 Old Home Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Black White etc. Armed Forces 1 Never Married 2 Married ☐ Yes 2 🗓 No ð 1 ☐ Yes 2 XNo Specify: Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Ann Niemeyer Edward Harold Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2913 Liberty Pkwy. Apt B Dundalk, MD 21222 Edward Wesley Kenney/son 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

Final Journey Crematory 10/28/12 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural f Funeral Service Lic Going "Home" Cremation Service P.O. Box 784 Clarksville, MD 21029 Beverly I. Heckrotte, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final leart tachere Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ronam Sequentially list conditions, Due to (or as a nonsequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🕱 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 8e 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No |@ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 27, Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month. Day, Year) 29c. License number 2012 MID 30. Name and addre eleted cause of death (Item 23a) (Type, Print) of person 1800 orleans Street Baltimore MD encu Man OCT 3 1 3. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1655 M Sujatha Rao Kalapala October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months Davs Hours (Month, Day, Year) 214-88-3503 Director 1 □ M 2 🛣 F 54 Yrs 01/17/1958 India Usual Residence of Decedent show r than "netural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Takoma Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8115 Hammond Avenue 20912 u.s.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: Asian Indian Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Consultant Travel Industry permit, Page 1 end 2 should be filed w Depertment of Health and Mental Hyg Important: if Item 27 is marked othe any injury or other treumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Prasada Rao Lamu Kamala Lamu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandhya Kalapala - Daughter 8115 Hammond Avenue, Takoma Park, Maryland 20912 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) |George Washington Cem| 10/28/2012 Adelphi, Maryland . Signature of Funeral Service Lifense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Days Immediate Cause (Final Physician/ Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Bacteremia 3 Daus Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Diabetic Ketoacidosis 3 Days that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 K No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဍ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause Michael Craig Murray. M

31. Date filed (Month, Day, Year)

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of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

70144

9901 Medical Center Drive, Rockville, Maryland 20850

October 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 Physician/ 540 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) **Director** 213-16-5538 1 □XM 2 □ F 92 01/10/1920 GERMANY 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f shortment be notified at Director BALTIMORE 1 Yes 2X No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37 STONEHENGE CIRCLE, 21208 USA items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant. If Hem 27 Is marked other than "natural", or items uny or other traumatic event, the Moules Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

12 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) MANAGER **JEWELRY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JULIUS KRUG IRENE GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH KRUG/WIFE 37 STONEHENGE CIRCLE, #5, BALTIMORE, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If It
any Injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHEVRA AHAVAS CHESED : 10/29/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility $\mbox{SOL LEVINSON \& BROS., INC.}$ 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): 1 des Medical Examiner 6deys bedrut Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ANo မျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Richard O Beng, 4D 10/28/12 Maryland DOOZOGCY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg. 40', Suite 260, 2700 Querry Loke Drive Bildinume, Ud 21209 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 27 2012 SHERRY J. LAWRENCE 6:15a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITIAN HOSPITAL BALTIMORE N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Country) Director 215-86-2825 39 1 M 2 X F 1-8-1973 MARYLAND permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health end Mentel Hygiane. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 showenty Injury or other traumatic event, the Medical Evaminer must be notified at 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1662 SHADYSIDE RD. 21218 IISA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ۵ 1 Never Married 2 Married 1 Yes 2 XNo Specify: 3 Widowed 4 N Divorced Specify: Completed BLACK Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) -0-TECH CARDINAL HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES F. LAWRENCE ETHEL E. COCKRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1662 SHADYSIDE RD. BALTIMORE, MARYLAND 21218 ETHEL LAWRENCE (MOTHER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial /2 Cremation 3 Removal from State METRO CREMATORY 10-29-2012 BALTIMORE, MARYLAND 4 Donat on 5 Gther (Specify) Licensed QNATHAN D. HIBNER2. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part f. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, six k, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cruse (Final disease or condition · Physician/ Arrhythmia
Due to (or as a consequence of): Medical resulting in death) **€**xaminer Atherosclerotic cardio voscular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attanding physicien and I for use as the burial-transit Physician: The law raquiras that the death cartificate ba exacuted Diabetes Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached t 9 Unknown 9 Unknown P.O. I signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital | funaral director, å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Attending 5 Pending 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kuthleen Tother fer ma D0062689. October 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUEN BUID L. Sha

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month GENEVA LEWIS 0445AM OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL SAINT AGNES N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year 2-8-1922 Months 115-18-6677 1 🗆 M 2 😾 F Director NORTH CAROLINA 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d Inside City Limits 10a. State 10c. City, Town or Location Director MD. N/A BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 3438 PIEDMONT AVE. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black, White, etc. 1 Never Married 2 Married ğ 3altimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify. 3 √ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC HOUSEKEEPING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CLARA EVERETT CHARLIE HUDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4119 EIERMAN AVE. BALTIMORE, MARYLAND 21206 JENNIFER SCOTT (NIECE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial /2 ☐ Cremat 3 Removal from State 11-5-2012 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) KING MEMORIAL PARK Service Acen JONAPHAX D. • HIBNE 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signa 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Deau Physician/ VENTRICULAR

Due to (or as a consequence of): disease or condition resulting in death) TACHY CARDIA Medical Examiner YEARS CORONARY Sequentially list conditions. Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death or unitative to construct within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY CORONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No HYPERTENSION 24a. Was an autopsy DIABETES 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 10/26/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S CATON AVE, BALTIMORE, MD 21229 MARUPUDI 900 SINDHUJA 31. Date filed (Month, Day, Year) OCT 3 1 2012 State

DHMH 17 Rev 06-2011

Registrar

		- For	State of M			artment of F				-	
	_	State Registrar				tificate of L			Reg. N	2012	34672
Physicia Medic		1. Decedent's Name (First, Middle, L Hans E. Lyons	,					2. Date of Dea Month October	oth D. 2	ay Year 2012	3. Time of Death
Examin		4a. Facility Name (if not institution, gi				4b. City, Town, or	Location of Death		40	c. County of Deat	h
,		Cherry Lane Nur 5. Social Security Number 6.		- / -	-4 - 1 - 4 1 1	Laure1	If Under 24 Hrs.	I a a	_	rince Ge	
Funeral Director		226-36-9716	1 X M 2 □ F		2 Yrs.	Months Days	Hours Min.	8. Date of Birti (Month, Day Dec 5	/ Year)	Co.	thplace (State or Foreign untry) ginia
show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
Maryla 18a-f s	rect	MD Anne A	runde1	Lau	re1						1X□ Yes 2 □ No
h the	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?
ms 22	ner	3523 Oak Road	I 10 Wes Deceded	to an in 11.6	140.1	20724		:6. Vo N-	US.		
er dea or ite	by Fu	11. Man'tal Status1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 X	No No	1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		14. Race - Ame Black, White	
ırs aft ural", I Exal	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1	1 ☐ Yes 2X No	Specify:			Specify: Bla	ick
72 hot "nat ledica	Completed	15. Decedent's (Specify only highest			(Give i	dent's Usual Occup kind of work done o	ation Iuring most of work	ing	16b. l	Kind of Business	Industry
vithin liene. or thar the M		Elementary/Seconday (0-12) 4th	College (1-4 or 5	i+)		ONOT use retired) Cruck Dri	ver			Private	_
filed valued by all Hyg	Be	17. Father's Name (First, Middle, Las	t)		-		18. Mother's Nam	ne (First, Middle,	Maider	Sumame)	
ild be Ment arked	은	Jacob Lyons					Anna St	arcia			
Shou h and 7 is rr traum		19a. Informant's Name/Relationship				ng Address (Street a				r Town, State, Zij	o Code)
Healt Healt tem 2		Phyllis Lyons/ 20a. Method of Disposition	<u>Wife</u>	20b. P		S Oak Road	1	MD 207		ocation - City or	Town. State
Page 1 nent of int: If i		1 Burial 2 Cremation 3		C	emetery, cren	natory or other place all Cemete	e)			urel, Ma	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service / ce	ensee		22						Home, Inc.
20 E 20 1	_	A P				7474 Lan				lle, MD	20785
		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final			n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	a. Pneumon		ionoo ofi:						1 Month
Examiner			b Dementi	·	ierioe oij.						1 Year
n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as		ience of):						
be executed sician and burial-transit	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Lung Ca			tic					
be existing buris	cal	l		,							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE:	d								
tendin r use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregna 2 🗌 Feta	ncy Il death 3 🛭	Ectopic pregnanc	ÿ			23d. Date of de	•
e dear the at thed fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of c	leath 5 L	Other (specify)				Month	Day Year
that the	by Ph	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco	use contribute to	the cause of death?
luires an sigr uld be	ed b	Chronic Kidney Disease								2 □ No 3 □ P	robably 4 🗆 Unknown
aw rec as bee	Completed	CAD						24a. Was a			topsy findings available completion of cause of
: The l		PAD							rmed?	death?	s 2X No
sician; certifi rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital:			Othe	ace of Death (Chec				
Physer this eral di	e: 10	27. Manner of Death	28a. Date of inju	ry	ER/Outpatier 28b. Time of	nt 3 🗆 DOA	4 X J Nursing H	ome 5 Resid		6 Other (Spec	ify)
ending sath. ir: Afte	ficat	1 X Natural 5 Pending 2 Accident Investigat		y, Year)	injury	M 1 🗆	? Yes 2 □ No		,		
or Atter fter de lirecto n by t	Certificate:	3 Suicide 6 Could no 4 Homicide determine				eet, factory, office		28f. Location (S City or Tow			ral Route Number,
pital o		29a, Certifier 1 X Certifying P	hysician: To the best of	my knowl	edge death	occured at the time	data and place a	nd due to the car	uso(s) s	and manner as st	atad
e Hos 124 h e Fun eleted	Medical	(Check 2 Medical Exa		xamination	and/or inves	tigation, in my opinio	on, death occurred a	at the time, date a	nd plac	e, and due to the	cause(s) and manner stated
To th within To th	-	29b. Signature and title of certifier	ATTE			29c. License				ate signed (Monti	
1600		1 postos	V PHY	212	MAN	D0057	216		0ct	ober 26	, 2012
12 Pur		30. Name and address of person wh	o completed cause of d	eath (Item	23a) (Type, F				,		
Stat	e	Michael Baako M 31. Date filed (Month, Day, Year)	D 3450 Fo			Road #209	Laurel,	MD 2072	4		
Pogietre		DCT 3 1 2	119 12		9 has	, del					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Secedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Yea) Hours Min. 245-32-4052 Director 1 □ M 2 🛛 F 89 NC Paga 1 and 2 should ba fliad within 72 hours aftar daeth with the Maryland mant of Haaith and Mantai Hygiane.
ent: If item 27 is marked other then "natural", or Items 23e or 28a-f show ury or other treumetic event, the Medical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3229 Massachusetts Avenue USA 21229 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African 1 Never Married 2 Married ፩ Maryland 21215-0036 1 Yes 2 No Specify: ^{Specify:} American Completed 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Family & Child Care Care Provider <u>10th Grade</u> BB 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ Connie Milton Della Milton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 Peggie Bell-Daughter 3229 Massachusetts Avenue Baltimore, Maryland ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If its any injury or of once. 1 X Burial 2 Cremation 3 Removal from State 11-03-12 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Lies nsee 638 N. Gilmor Street Baltimore, Maryland 21217 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AtherosuRotic Cardiovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of c te has baen signad by tha attanding physician end page 2 should ba datechad for usa es tha burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law raquiras that the death cartificate be Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Day 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Hospital or Attending Physician: The within 24 hours after death.
To the Funerel Director After this certific, tel complataly filled in by the funeral director, pag 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 🗖 No ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nst injupantimp D0057465 Smith A SZC3 Baltimore MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSKAJAPAKSEMD 2835 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 3 1 2012 Serve S. failed Registrar DHMH 17 Rev 06-2011

OF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ a M Wenxiang Liu 0230 October 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Apr 22 Director 220-85-8518 73 1 M 2 K F China Yrs Usual Residence of Decedent ii Hygiene. I other than "neturel", or items 23e or 28e-f show vent, ithe Medicel Examiner must be notified at 10b. County 10c. City, Town or Location the Marylend 10d. Inside City Limits MD Montgomery Rockville 1 Yes 2 X No ᅙ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral China 14903 Forest Landing Circle 20850 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>ک</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Asian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Manufacturing traumetic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file of Heelth end Mentei H Item 27 is merked of ည Xuesong Zhang Jingxuan Liu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yongli Chen/husband 14903 Forest Landing Circle Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1 of Papertment of H importent: If its any injury or of once. 1 Burial 2 Ceremation 3 Removal from State Final Journey Crematory 10/31/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 21029 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying equentially list conditions, Examine Due to (or as a consequence of): siclen end burlel-trensit Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ettending physicien Physician/Medical Box 68760 the 68 IF FEMALE: OSO 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No Day 5 Other (specify) deteched g 🔲 Unknown g 🗌 Unknown P.O. ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cete hes been signed pege 2 should be der 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificete 1 ☐ Yes 2 🔀 No 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) hospice 1 Yes 2K No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours efter deeth.
To the Funerel Director: Afte completely filled in by the fur 1X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Qertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗷 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R143201 10.28.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 31 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29, 2012 6:55 A M Carroll Ridgley Lemmon Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Director 215-24-9158 1 XM 2 - F Maryland 84 Oct. 8, 1928 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland | Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 3982 Norrisville Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working n and Mental Hygiene.

7 is marked other than "raumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Firefighter 8 Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude (unk) Astra William Frederick Lemmon other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any Patty Chalk / Daughter 1824 Midsummer Lane, Jarrettsville, MD 21084 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11-2-2012 | Baltimore, Maryland Moreland Memorial Pk Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _ach line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Canell Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or se a consequence of): Exami Due to (or as a consequence of) resulting in death) Last Physician/Medical Cimmon P.O. Box 68760 the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed M800288673 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an performed? 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **(**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Vatural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nurnber or Rural Route Nurnber, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yea Y impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 208 PLUMTREE ROAD Suite ANGELO 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 3 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $0ct^{Month}$ Day 2012 Year 29, Clinton Lawrence Luers

7. Age (In vrs. last birthday)

10c. City, Town or Location

Randallstown

90

12. Was Decedent Ever in U.S.

If Yes, Give Year or Dates

College (1-4 or 5+)

23a. Part 1. Enter the disease, or complications that caused the d. ath. Do not enter the mod shock, or heart failure. List only one cause on each line.

Due to (or as

Due to for as a consequence of

Due to (or as a consequence of):

Pregnant at time of death

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Armed Forces? 1124 Yes 2 \(\sum \) No \(1944-\)

1946

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Randallstown

10f. Zip Code

21133

16a, Decedent's Usual Occupation

Drafsman

20b. Place of Disposition (Name of

cemetery, crematory or other place)

3 Cther (specify)

1 ☐ Yes 2 → No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

Lake View Memorial Park 11/6/2012

34676

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Maryland

4c. County of Death

Baltimore

10g. Citizen of What Country?

United States

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

Were autopsy findings available prior to completion of cause of

1 Yes 2 No

Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

death?

Sykesville, MD

Westinghouse

Specify:

14. Race - American Indian,

White

Black, White, etc.

8. Date of Birth (Month, Day, Year)

10/3/1922

18. Mother's Name (First, Middle, Maiden Surname)

R. Name and Address of Facility
rrier-Oueen Funeral Home and Crematory, P.A.
12 W. Old Liberty Rd. Winfield, MD 21784

24a. Was an

26. Place of Death (Check only one)

autopsy

performed'

Helen T. Borgman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4103 Teklen Dr. Westminster, MD 21157

5:00 A M

			P
		For State Registrar	
		1. Decedent's Nam	ne (First, Mi
Physicia Medic		Clinton I	Lawre
Examin		4a. Facility Name (i	f not institu
		3807 Brow	vn Hi
Funeral	1	5. Social Security N	
Director		217-12-84	485
3		Usual Residence	_
and sho	ō	10a. State	10b. Cou
Maryl 28a-f stifiec	rect	MD	Balt:
the lor 2	Ω	10e. Street and Nu	
with with ust b	era	3807 Brov	vn Hi
leath Items	Fun	11. Marital Status	
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JOG	ted	3 XX Vidowed	4 Divor
21215-0036 within 72 hours after death with the Maryland giglene. rer than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	Completed by Funeral Director	(Spe	15. Dece
2121 within 7 giene. ner than t, the M	Com	Elementary/Sec	ondary (0-1
Ø ≥ 9 ₽ ±	0		

4a. Facility Name (if not institution, give street and number)

10b County

Baltimore

15. Decedent's Education (Specify only highest grade completed)

19a. Informant's Name/Relationship (Type, Print)
Sandra Sparrow (Daughter)

4 Donation 5 Other (Specify)

1 X Burial 2 Cremation 3 Removal from State

1xxM 2 F

3807 Brown Hill Rd

3807 Brown Hill Rd.

1 Never Married 2 Married

3XXWidowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

August J. Luers

21. Signature of Funeral Service 1

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

23b. Was decedent pregnant

Yes 1 ☐ Yes ∠ ☐ Unknown

in the past 12 months?
1 ☐ Yes 2 ☐ No

25. Was case referred to mediexaminer?

that initiated events resulting in death) Last

IF FEMALE:

disease or condition resulting in death)

permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, til once.

Physician/ Medical Examiner Examine

Baltimore, Maryland

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and as the burial-tran Division of Vital Records, P.O. Box 68760 use a signed by the a page 2 funeral filled in by the

Physician/Medical

þ

Completed

Be

within 2 To the the X

Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and∕title of certific 29c. License number 29d. Date sign#d (Month, Day 30. Name and address of pers 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month LOE BARBARA 6:10 AM October 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Manor Care-Potomac Potomac If Under 9. Birthplace (State or Foreign Country) China Social Security Number 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Months Hours Min Dec. 14 Year 924 220-60-1806 87 Yrs. China Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Montgomery Chevy Chase 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4515 Willard Avenue #1001S 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2K No Specify: 3
Widowed 4 Divorced Specify: Chinese 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Program Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Regional U.S. Government Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Loe Theresa Tseng 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Trailridge Court, Potomac, Maryland 20854 Agnes P. Loe Li/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) Robert Address Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between BREAST CA. Immediate Cause (Final METASTATIC Onset and Death disease or condition resulting in death) Due to (or as a consequence of): THRIUE FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery

Physician/ Medical Examiner

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Physician/

Medical

10a. State

Examiner

Funeral

Director

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permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

notified at

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Funeral

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Completed

Be

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with the Maryland

Examine nding physician and use as the burial-transit Physician/Medical use ģ signed by the a ģ Completed should funeral director, Be မ Certificate:

1 Yes 2 No	4 Pregnant at time of death 5 Other (specify) Unknown	Month Day Year
art II. Other significant conditions	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
		24a. Was an autopsy performed? 1 ☐ Yes 2☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
5. Was case referred to medical	26. Place of Death (Che	ck only one)
examiner? 1 Yes 2 No	Hospital: 1	Home 5 ☐ Residence 6 ☐ Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 \[\text{Yes} \] Yes 2 \[\text{No} \]	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e Place of Injury - At home form street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00057458

29c. License number

City or Town, State)

29d. Date signed (Month, Day, Year,

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law is within 24 hours after cleath.

To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 s.

State Registrar

Medical

(Check

only one)

Pinky Singh, M.D. 31. Date filed (Month, Day, Year)

3 [

29b. Signature and title of certifier

8218 Wisconsin Ave., #305, Bethesda, Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Reg. No. Recedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ nonge Month 5:30 PM Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** Anne County of Deat 10015 If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) If Unde 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Min. 215-60-5225 **Director** 60 1 X M 2 □ F Mar 18, 1952 Maryland Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Hanover 1 Yes 2X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21076 92 Chesapeake Mobile Court United States "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. White 3 Widowed 4 X Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than of the sud Mental Hygiene.

27 is marked other than r traumatic event, the Man College (1-4 or 5+) Elementary/Secondary (0-12) Supervisor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ferdinand Mongeon Mildred Catherine Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Rebecca Mongeon / Daughter 2320 Blue Ball Rd., Apt. B, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/23/2012 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END-STAGE MULTIPLE MYELOMA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Po in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy Yes 2 No funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No : After t 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 10 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

HYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W- KOMEUS, M.D

31. Date filed (Month, Day, Year)

20051029

2001 MEDICAL PRWY ANNAPOLIS, MD 21401

10-20-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Month MARGARET H. McCAULEY 8:05P M Medical Oct 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 17,1920 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours Min Director 220-05-0502 1 M XX F 92 Yrs Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Crofton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21114 1784 Shaftsbury Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married \$ 8:05 р.ш. Maryland 21215-0036 1 Yes 2X No Specify. White Specify. 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. N/A Stewart Dept. Store Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 မှ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1784 Shaftsbury Ave. Crofton, Md. 21114 Russ Morgan (Son) OCTOBER 25, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Date 20c. Location - City or Town, State X1\(\) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-1-2012 Baltimore, Md. 21. Signature of Funeral Service Licensee Lassahn Funeral Home Baltimore. Md. 21236 22. Name and Address of Facility Justin Brown 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) sician and burial-transit Exam Hoapital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Records, P.O. Box 68760 MARGARET McCAULEY IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 ☐ Yes 2 🔀 No 9 ☐ Unknown To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) မှု 1 ☐ Yes 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

MORGAN,

TRACIE L.

31. Date filed (Month, Day, Year)

CRNP

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Myrtle Multrie 2012 1248 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll County General Hospital Westminster Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours 1 🗆 M 2 💢 F 1-13-1929 **Director** 250-50-2492 SC 83 Yrs Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho 10a. State Director 1 ☐ Yes 2X No Carroll Taneytown MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 113 Saddletop Drive 21787 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 \(\sum \) Yes 2 \(\sum \) No \(Specify: \) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Examiner Armed Force 2 should be filed within 72 nouses....th and Mental Hygiene.
27 is marked other than "natural", or ò þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates Specify: African-American 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Damestic Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be to Department of Health and Mentals Important: If item 27 is more any injury or other ျှ Issac Hamilton Sr. Lucille Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Saddletop Drive, Taneytown, MD 21787 James Moultrie Jr.,/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-3-2012 Morning Glory Cemetery Georgetown, SC 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. of Funeral Service Licensee 21. Signatule 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic Cardionscular Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a sonsequence of). burial-transit Due to (or as a consequence of): inding physician ause as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 io the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in Part 24. Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 2- No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State

Registrar

DHMH 17 Rev 06-2011

only one

31. Date filed (Month, Day,

29b. Signatur

and title of certifie

Year)

3 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Æ2. Registrar's Sign

MAHMOOD

Rida

29c. License number

29d. Date signed (Month, Day, Year)

Rucd Westminster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/29/2019 8:34а м James Clayton McNeil, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** Days Hours Min. 0 3 / 28 / 1 95 7 Director 1 🗖 M 2 🗆 F 219-62-6869 55 Usual Residence of Decedent 28e-f shov th end Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28e-f shor traumatic event, the Medical Examination motified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6139 St. Regis Road 21206 U.S.A within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify:Black 1 ☐ Yes 2 🙀 No Specify Completed 3 DWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpentry Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Clayton McNeil, Sr. Annie Snead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 Department of Health Important: If Item 27 eny Injury or other trong once. Wanda McNeil - wife Regis Rd. Balto. MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 Burial 2000 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 10/30/12 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD 21206 F.H 4210 Belair Rd. Cullen Chatman-Harris 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Pnysician/ ECTAL disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ate hes been signed by the attending physician end page 2 should be deteched for use es the burlal-trensit Gause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 (प्रमाद IF FEMALE: NA 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ LUNGS, BRAIN, C-SAINE Completed 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Yes 2 No 25. Was case referred to medical BB 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 12 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death October 27, 2012 Physician/ 8:00 P M Wing Keung Mok Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg 5 Mallory Court If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Aug 24, Hong Kong 59 Director 217-83-3041 1 🛛 M 2 🗆 F ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 XYes 2 No Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 20879 Funeral Hong Kong, British 5 Mallory Court Hyglene. other than "natural", or items ent, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛭 No If Yes, Give 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Garment Manufacturing Production Manager Ith and Mental Hygien 27 is marked other the r traumatic event, the 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fong Law Hing Mok permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Mallory Court Gaithersburg, MD 20879 19a. Informant's Name/Relationship (Type, Print) Lany Mok/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Final Journey Crematory 10/31/12 21. Signatur of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pancreatic Cancer with Metastases Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months? Month Pregnant at time of death Yes 2 □ No g Unknown been signed by the s should be detached 9 🗆 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Director: After this certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\overline{\Sigma}\) Residence 6 \(\sum \) Other (Specify) 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 5 Pending iniury 1 X Natural after death. Investigation 2 Accident
3 Suicide
4 Homicide Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c, License number October 30, 2012 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Coleman, M.D. 1355 Piccard Drive Rockville, MD 20850

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCTOBER John Lawrence Morgan 12:10 PM Medical 4a. Facility Name (if not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTE 4c. County of Death
BALTIMORE Examiner 4b. City, Town, or Location of Death TOWSON 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 076-30-8965 Director 1 🛛 M 2 🗆 F 75 Sept 1, 1937 Pennsylvania Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "netural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 □ No MD. n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2211 W. Rogers Ave. #237 USA 21209 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Itimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify.White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical Doctor Medicine NORGAR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alvin Morgan Loretta Goetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie B. Morgan/ Wife 2211 W. Rogers Ave. #237 Baltimore, Md. 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. 4 Donation 5 Other (Specify), Towson, Md Hilltop Service Co. 110-29-12 ^{22. Name and Address of Facility} on Funeral Home, 1050 York Rd. Towson, MD. Signature of Funeral Service Lious 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani acute infective endocarditis weeks disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner weeks metricillin res istant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examine or Attending Phyaicien: The law requires that the death certificate be executed attending physician end I for use as the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month this certificate has been signed by the srail director, page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ad title of certifier 29d. Date signed (Month, Day, Year) OCTOBER 26 Zeiz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARRON CHARLES N Charle S NOZENOT 670 32. Registrar's Signature 31. Date filed (Month, Day, State OCT 3 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g933 I1-7-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 11:10P M Dolores Anne Majewski Oct. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Senator Bob Hooper House Harford Forest Hil: Social Security Number 9159 If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) Director 217-14 1 🗆 M 2 🔀 F 88 July 10,1924 Maryland Usual Residence of Deced permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hyglene. Importent: If item 27 is marked other then "nature!", or items 23e or 28e-f show with injury or other treumetic event, the Markel Examiner would be matified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bel Air 1 Yes 2 XNo Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1603 Martha Court Unit 304 21015 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Guzinski Mary Zacharski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , MD 21015 Unit 304 (Daughter) 1603 Martha Ct. Bel Air Linda S. Lanham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 11/02/2012 Dundalk, Maryland 21. Signature of Funeral Service Ocens 1100 Neiser 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 whe 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physicien: The lew requires that the death certificete be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Dolole Other: 4 Nursing Home 5 Residence 6 Other (Street) PCE 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ם' se of death (Item 23a) (Type, Print) Name and addres 31. Date filed (Month, Day, Year) State

Registrar

3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MORRIS Physician/ TOR OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number)

NOTHWEST HOSPITAL CENTER Examiner Town, or Location of Death 4c. County of Death RAMPALLITOUR BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Birthpia. Country) NY 1 X M 2 T F Hours 0971771919 Director 120-03-6900 93 Usual Residence of Decedent shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 ASSOCIATED WAY, #407 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SALESMAN APPLIANCES Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ **JACOB** WARSHOFSKY **EVA** RUBIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMIE MORRIS / DAUGHTER 2320 SOUTH CIRCLE DRIVE, ANN ARBOR, MI 48103 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ANSHE EMUNAH — 10/26/2012 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD . Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a ATHEROSCLEROTIC CARDIOVASCULAR Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ retail 00.
☐ Pregnant at time of death
☐ Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year the. signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autons 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation
Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) d titlevof co 23 DCTOBER O Name and address of person who completed cau AVVERAKALLI se of death (Item 23a) (Type, Print) ROAD MORTHWEST CEN

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

30

401

OLD COURT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ Day Year CRAIG PAUL MULLETT, SR. 2:38 AM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Glen Burnie Cr5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Director 212 46 6196 1 X M 2 □ F 65 Maryland 06 30 1947 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Pasadena 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7880 W. Riverside Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. à 1 Never Married 2 Married filed within 72 hours after 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) 2 Transportation **BGE** Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Albert Mullett Dorothy Hazel Vernon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 Sharon Mullett - Wife 7880 W. Riverside Dr Pasadena, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/18/12 Baltimore, MD Bayview Crematory: 21. Signature of Furtieral Samuel Licenses 22. Name and Address of Facility GJ Gonce Funeral Home PA 21122 Pasadena, MD 169 Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ abetic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the ettending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autonsy death? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Dinpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After the filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Hospital edical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 0073466 O Ctober 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OBERT drive, 31. Date filed (Month, Day, Year) 32. Registrar's State 30 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE BRIGHTVIEW ASSISTED LIVING CATONSVILLE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Rirth Days Hours Min. (Month, Day, Year) Director 76 212-32-5438 1 □ M 2 □XF 3-14-1936 MARYLAND r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A BALTIMORE MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 USA 210 N. EDGEWOOD ST. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: BLACK 3 1 Widowed 4 □ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) -12--0-DOMESTIC HOMEMAKER Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental should be WAYDELL PRYOR VELMA WALTON off. Page 1 and 2 shou... 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6076 LAKEVIEW CIR. FAIRFIELD. ANGELA DORSEY (DAUGHTER) CA. 94534 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200) 20c. Location - City or Town, State = 6 1 X Burnal 2 Cr mation 3 Removal from State Important: I any Injury o GARRISON FOREST VETERANS 10-29-2012 OWINGS MILLS, MD. 4 Donation 5 Other (Specify) Signature of Fundal Ser D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE JONATHAN 1721-27 N. MONROE ST. BALTIMORE. MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician diseas or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examir the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Pregnant at time of death detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🛂 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗆 No 1 🗌 Yes 1 🗌 Yes 2 completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSIGNING examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗌 Yes 2 🗀 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Matural 5 Pending Accident 1 Yes 2 No s after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 30. Name and address of person State 32. Registra Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dallas E. Norman Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Klins ose awar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 213 28 8538 1 🛮 M 2 🗆 F Director 80 01/20/1932 Maryland Usual Residence of Dec 28a-f show 10a. State 10b. County than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 913 Lance Avenue 21221 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Specify: white 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. traumatic event, the and Mental Hygie is marked other Mixer <u>Cement Company</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (unknown) (unknown) Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra. 913 Lance Avenue Essex Maryland 21221 Patricia Pratt (personal Rep) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Holly Hill MemGardens 11/2/2012 4 Donation 5 Other (Specify) Baltimore Co., Maryland Funeral Service Licensee Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a List only one cause on each line. . Enter the dise 23a. Part shoot, or heart failu Immediate Cause (Final disease or condition resulting in death) or heart failure Interval Between Onset and Death Physician erotic Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physiciar Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Year Pregnant at time of death Month Day 1 U Yes 2 D 9 Unknown page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number mull to mo 27/2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Fran Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 24 Oale Eugenia 2012 6:23 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk Future Care North Point 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral August 8, 1922 Months Days 213-12-8186 90 Marvland **Director** Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Baltimore Dundalk 1 Yes 2 No MAryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral with 1 23a 21222 USA 750 Aldworth Road items 2 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: White If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates ed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Rhodes William Myers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21047 2003 Copperwood Way, Fallston, Maryland Daughter Debbie Grau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 27 1 X Burial 2 Cremation 3 Removal from State BAltimore, Maryland 2012 Oak Lawn Cemetery 4 Donation 5 Other (Specify) ign to re <u>of Jun</u> well Service Licensee onnelly Funeral Home Of 110 Sollers Point Road, Dundalk, P.A. Dundalk, Md. MINEM 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EMENTIA disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use هد المامة الم Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) a Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an าสร completed filled in by the funeral director, page 2 autopsy certificate 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 Natural 2 No 24 hours after death Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. eck Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 orly one) 29b. Signature and title of certific 29c. License number OCTOBER 26,2012 00060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EN RUN PS #E, ESSEX, MS

Registrar

State

31 Date filed (Month Day Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Pegg OPM October 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Beltimore
If Under 1 Year | If Under 24 Hrs. Irvington Future Care 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
April 12,1927 West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 💢 F 217-20-5740 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinet must be notified at once. Director 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 South Rolling Road 21228 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. White þ Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ward Tase Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 South Rolling Road Catonsville, Maryland 21228 John Parker, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/31/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mixed stage dementia disease or condition resulting in death) /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). spital or Attending Physician: The law requires that the death certificate be executed burlal-trans resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for Month Year Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☑ No the 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No genera 24a. Was an performed Polymynlgia certificate Hypertension 1 □Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 028462

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Future Care

Boston

31

31. Date filed (Month, Day, Year)

October 30, 2012

Irvington 22 South Athol Avenue, Bultimore

12-08096 John Planters Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	inters		Redistrar	ertificate of		o Mental n		g. No. 201	2 3469			
	Physicia I Exami		1. Decedent's Name (First, Middle,Last) John	Planter	'c		2. Date of Death Month October 25	Day Year	3. Time of Death 1438 hrs			
			4a. Facility Name (if not institution, give street and number)		b. City, Town, or	Location of Deat		4c. County of Death				
F	uneral		Rear of 2200 Annapolis Road 5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	Baltimore If Under 1 Yea	r If Under 24Hr	s. 8. Date of Birt	NA h(MM/DD/YYYY) 9. Bir	rthplace (State or			
	irector		215-33-1545 1XM 2_F 21	Yrs.	Months Day	s Hours Mir	_	Foreign				
	any		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Location	on				10d. Inside City Limits			
7	r show	ō		Baltimore					1 Yes 2 No			
Many	or 28a-	Director	10e. Street and Number 4610 York Road		10f. Zip Code 2121	12	10	g. Citizen of What Cou USA	ntry?			
thing the	ems 23a	eral	11. Marital Status 12. Was Decedent Ever in Armed Forces?			spanic Origin? (S	pecify Yes or No-	14, Race - Amer	ican Indian, Black,			
Per deaf	", or its	by Funeral	3 Widowed 4 Divorced If Yes, Give Year		Yes 2 X No		rtiouri, oto.)		African erican			
o o di	natura	ed by	15. Decedent's Education (Specify only highest grade completed)	16b. Kind of Business/								
336	penint. reges I am 2 should be fined within 1.2 hours arter deain with the Madyand operations of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade NA Never worked Unemploy									
MD 21215-0036	Hygier ed other t, the M	e Co	17. Father's Name (First, Middle, Last) John E. Planters,	Cm			e (First, Middle, M	,				
212	d Menta s mark ic even	To Be	19a. Informant's Name/Relationship (Type, Print) Moties	ろと。 19b. Mailing	Address (Stree	Shawn to et and Number or		Brown ber, City or Town, State	n-Moten e, Zip Code)			
Z,	cm 27 i		Shawntay D. Brown-Moten	4610 b. Place of Disposi	York Roa	ad Baltin	nore, Ma	ryland 212	12			
nore	ages I int of H at: If it		1 K Burial 2 Cremation 3 Removal from State	Trimity of oth			01-12	Dundalk,				
Baltimore,	epartme nporta	- 3	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ame and Address		/lie Fun	eral Home	P.A. 21217			
	/sician	- 5	23a. Part I. Enter the disease, or complications that caused the dea					timore, Mar	Approximate Interval			
IN	le diral aminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wool						Between Onset and Death			
			or condition resulting in death) Due to (or as a consequence b.	a of):								
		niner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	∍ of):								
Į.	ansit	edical Examiner	events resulting in death) Last Due to (or as a consequence d.	e of):								
, a	ysician and burial - transit	dical	UNPENDED AMENDED									
8760	ng physias the bu		IF FEMALE: 23b. Was decedent pregnant in the		al death 3	Ectopic pregna	ancy	23d. Date of deliver	y Day Year			
Box 68760,	within 24 hours after the carbon of the carb	Physician/N	past 12 months? 4 Pregnant at time of 1 Yes 2 No 9 Unknown 9 Unknown	doath	ner (Specify)							
P.O. E	ned by the detached f	by Phy	Part II. Other significant conditions contributing to death but no	at resulting in the un	nderlying cause o	given in Part I.		pacco use contribute to				
Js, P	en sign						1 Yes	2 ✔ No 3 Pro	bably 4 Unknown			
Division of Vital Records,	this certificate has been signed I director, page 2 should be det	Completed					autops perform 1 ✓ Yes 2	y prior to ned? death?	completion of cause of			
tal R	certifica ector, pa	Be	25. Was case referred to medical examiner? [Hospital: 1] Innatient 2	_<	26.Place	of Death (Check	only one)					
of Vi	After this funeral dir	မ	1 Yes 2 No losspiral 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of In		Other Nursing at Work?		Residence 6 🗹 Othe	r: Scene			
ion	death. tor: A: y the fur	ation	1 Natural 5 Pending Oct 25, 2012	1426 hrs	1,	Yes 2 ✓ No	Subject shot					
Divis A refer	ours after death	Certification:	3 Suicide 6 Could not be determined (Specify) Vacant L		t, factory, office b	ouilding, etc.	or Town, St		iral Route Number, City			
e Hoeni	within 24 hou To the Funer completely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge of the control of the control of the certifying Physician: To the best of my knowledge of the certified of th	edge, death occurr			due to the cause	e(s) and manner as stat	ed.			
- F	To th comp	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated. 29b Signature and title of certifier	and/or investigati	29c. Licens		at the time, date a	29d. Date signed (Mo				
			(V purterkens)		O.C.	M.E.		October 26, 201	2			
1.	/		80. Name and address of person who completed cause of death (Ite Laron Locke MD. Assistant Medical Examine)		Itimore Stree	t, Baltimore.	MD 21223					
1 "		ate	31. Date filed (Month, Day, Year) 32. Renstrar's Signal (Month, Day, Year)	ature	Mal							

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ eonine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Heartlands Senior Living Village Ellicott City 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Director 431-40-1006 1 | M 2 X F 90 06/10/1922 AK Usual Residence of Dec er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3004 North Ridge Rd., Apt. 412 21043 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 If Yes, Give Year or Dates. 47 - 53 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Real Estate Agent Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked off any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Gilmore Louis Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Sparrow Hill Ct., Catonsville, MD 21228 Kathleen S. Provance / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 10/27/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Furneral Service Licensee Hubbard Funeral Home Daniel Simons 4107 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition End Stage Dementia Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: Other: 2 🗆 No 욛 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 M other 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my reliable death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Uskajapame MD 00057465 10/26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 2835 Smilh AV 5203 NS Rajapak semo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 3 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State o	f Marylan	d / Depa Cen	rtment of F tificate of D	lealth and N Death	/lental Hyg	giene Reg. No. 2 (012	34694
			Registrar 1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath	V	3. Time of Death
	Physicia Medic		Edwin P. Post						October	25,	2012	2:50 PM
, P	Examin		4a. Facility Name (if not institution,	give street and num	ber)			Location of Death			ty of Death	
			Sunrise 5. Social Security Number	6. Sex	7. Age (In yrs. la	est hirthday)	Columbi	a If Under 24 Hrs.	8. Date of Birt	Howa		lace (State or Foreign
	Funeral Director		101-16-2973	1 X M 2 □ F		Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Count	New York
			Usual Residence of Decedent		89				June 9,	1923	1	
	yland f sho	ctor	10a. State 10b. County			y, Town or Loc	ation					0d. Inside City Limits 1 ☐ Yes 2 【X No
	r 28a- notifi	Director	MD Howard	1	Coli	ımbia	10f. Zip Code			10g. Citizen o	of What Coun	
	vith th	ral	6500 Freetown F	Road			21044		Ì	USA		
	eath v tems er mu	Funeral	11. Manital Status	12. Was Dece	edent Ever in U.S			ispanic Origin? (Sp In, Mexican, Puerto			ace - Americ	
36	ifter d ", or i	۵	1 Never Married 2 Marri	ied Armed For 1 A Yes If Yes, Giv	2 No		☐ Yes 2 No		, mount, ocon	Spec		
Š	ours a atural	eted	3 XWidowed 4 Divorced	Year or Dat's Education		16a Deced	lent's Usual Occup	ation	- 15		Business/Inc	
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212	withir giene er tha		12	Odliege (1		Build:	ing Inspe			HUD		
pu	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, L					18. Mother's Nam Anna Jos			me)	
₹ 2	Mark mark		George Bush Pos			10h Mailia	an Addraga (Stmat	and Number or Rui			State Zin (Code)
Σ	2 sho Ith an 27 is		Rosemary Barton		ter			s Place;				
ē,	1 and of Hea item other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other place	1	Date		on - City or To	
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Gremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from pecify)	State Hil	1top S	ervice Co	orp. 10/2	9/2012			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funers San be V	igunse			. Name and Addre					ork Road
_	ÇO = e o	2 1	23a. Part 1. Enter the disease, or	Mey				Funeral			owson	, MD 21204 Approximate
3	2	5 6	shock, or heart failure. List of Immediate Cause (Final	nly one cause on ea	ach line.			ig, saarr as cardiae	or roop actory as	,	1	Interval Between Onset and Death
	nysician/ Medical		disease or condition resulting in death)	a. Alz	heimer'	S Dise	ase				\rightarrow	/ years
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1760	icate l g phys	Jedi.		d								
89	eath certificate attending phy d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy aldeath 3 [Ectopic pregnan	су		23d. Da		
Box 687	death he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of		Other (specify)				Month	Day Year
P.O.	that the dea led by the a detached f		Part II. Other significant condition	ons contributing to o	death but not re	sulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
S, F	requires th been signe should be	Completed by							1 🗆	Yes 2 🛣 N	o 3 🗆 Pro	bably 4 🗆 Unknown
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Ξ	Physic this ce al dire	₽	1 ☐ Yes 2 🔀 No		Inpatient 2	ER/Outpatie	nt 3 🗆 DOA					ssisted Living
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siol	or Attend fter death irector: / in by the	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide detern	not be 28e. Place			reet, factory, office				mber or Rura	al Route Number,
Division of Vital Records,	s afte		I Tomicae actem	build	ling, etc. (Specif	(y)			City or 10	wn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	(Chack 2 Medical I	Physician: To the Examiner: On the bay Nurse Practitione	asis of examination	on and/or inves	stigation, in my opin	ion, death occurred	at the time, date	and place, and	due to the c	ause(s) and manner stated.
	Vithir Vomp		29b. Signature and title of certifie		m		29c. Licen	se number		29d. Date si	gned (Month,	Day, Year)
	WAX		30. Name and address of person	who completed call	use of death (Ite	m 23a) (Type,	D5653	-		Octobe	er 26,	2012
	11.0		Harry Li, M.D	. 8600 S	nowden	River	Pkwy #301	L; Columb	ia, MD	21045		
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Sign							
	Regist	ar	OCT 3 1 2012	Census	B. 14	railed			-			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25 Day Physician/ Month 1/15 AM Joseph Norman Pokrywka 2012 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sauare Rosedal Bactimore FAANKLIN HUSPITCIL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 220-20-6743 Director 1 X M 2 D F 82 March 11 1930 Michigan Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21234 8800 Walther Blvd. #4121 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Docking Pilot Tug Boat Master Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Joseph Pokrywka Elizabeth Derengowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frank Lanocha/ Attorney 4205 Manorwoods Drive Glenn Arm, MD. 21057 Baltimorė, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation _3 ☐ Removal from State 11/2/2012 Timonium, MD. Dulanev Valley Mem. 4 ☐ Donation # K Other (Spartypmbment ^{22. Name and Address of Facility}son Funeral Home, 1050 York Rd. Towson, Md 21. Signature of F eral Service Licence 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Frysician/ Aortic STENOSIS disease or condition resulting in death) evere Medical Due to (or as a consequence of) Examiner ardioGenic Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, To the Funerei Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by e Hospital or Attending Physician: The law requires to 24 hours after death.
9 Funerel Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Heur 1 10-25-2012 RESOOOO MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md 21237 9000 FRANKLIN SQUEER DR

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

DCT 3 1 2012

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08010 State of Maryland / Department of Health and Mental Hygiene Phillip Frank Plummer 2012 34696 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Date of Death Physician/ Month 1700 hrs Medical Examiner October 22, 2012 Phillip Frank Plummer c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Edgemere 7823 Denton Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 63 February 16, 1949 Country) Maryland 1 XM 2 F 219-52-3724 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Baltimore Edgemere s 23a or 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hyggiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21219 USA 7823 Denton Avenue uneral 14. Race - American Indian, Black, 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify:White 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Seagrams Distrillery 12 years Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Plummer Dorothy Nodonly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Granddaughter 3118 Wallford Drive Apt F., Dundalk, MD. 21222 Erica K. Krawczyk 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition October Burial 2 X Cremation 3 Removal from State crematory or other place)
Bayview Crematory 24, 2012 Baltimore, Maryland Donation 5 Other Specify. Conneriy Fufferal Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Sonature of Muneral Service Ligenses Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a, pt. II, 27, per me, g933 11-14-12 sm X UNPENDED has been signed by the attending physician 2 should be detached for use as the burial -The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the 1 Live birth Month 3 Ectopic pregnancy Dav 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 V Unknown Mesothelioma Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed' Yes 2 No 1 🗸 Yes director, 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 2 No 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) filled determined 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifie October 23, 2012 O.C.M.E.

S.

OCME 2006

Registrar

DHMH 17 Rev 1/2001

State

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

gistrar's Signatur

Assistant Medical Examiner

Name and address of person who completed cause of death (Item 23a)

2012

OCME

Laron Locke MD.

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician OCTOBER 26 2012 Joan Jacqueline Pullin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Levindale Hebrew Geriatric Center Baltimore If Under 1 Year If Under 24 Hrs.

Page Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 21 1934 Maryland 78 Apr. 18, 219-30-0570 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10a. State 10b, County 1 ☐ Yes 2 No Maryland Harford Director Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21085 415 Hardin Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. þ 3 ₩idowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Receptionist 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora Iona Hunter William Harry Siler ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 415 Hardin Drive, Joppa, Maryland 21085 Phyllis Biagi / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gdn 10-31-2012 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 lessica thibeaver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOPULMONARY **Physician** /Medical Due to (or as a consequence of): YEARS Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, hours after death. filled in within 24 hours a To the Funeral C To the Hospital 0

State

MD PAMLINE DALEY 31. Date filed (Month, Day, Year)

OCT 3 1 2012

(Check only

29b. Signature and title of certifier

2434 V 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

West

29c. License number

00062895

Belvedere Ave.

29d. Date signed (Month, Day, Year)

OCTOBER 26, 2012

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 26, 2012 Physician/ Mildred Quesinberry 10:25 AM Breidenbaugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Fallston House of Jubilee Assisted Living Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours **Director** 212-20-9495 1 🗆 M 2 🔀 F 96 Aug. 24, 1916 Maryland Usual Residence of Decede th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Harford Jarrettsville 10e. Street and Number 10g. Citizen of What Country? Funeral 4200 Madonna Road USA 21084 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Clothing Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filk tment of Health and Mental I rant: If item 27 Is marked o မ Charles Phillip Breidenbaugh Rickie Auguste Koerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill C. Quesinberry / Son 1711 Baldwin Mill Road, Fallston, MD 21047 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of It Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Presb. Cem. 11-2-12 White Hall, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A.

McComas Funeral Home, P.A.

Beggins Beggins Home, P.A. MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dement 4 car disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical Assisted Other: 4 Nursing Home 5 Residence 6 KOther (Specify) 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Living 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/XNatural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 34208 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) OCT 31

LINDA A-WALSH

3718 Norrisville Ld, Ste C, June Hsville MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:00 PM 10 201 Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON OWSON Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Day, Year) 1931 Days Hours Min (Month **Director** 137-26-7088 New Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 🛣 No Baltimore Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with the thit and Mertal Hyglene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1 traumatic event, the Medical Examiner must be 1. Funeral 21042 9114 East Staymen Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1XXYes 2 No
If Yes, Give 1947-Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1953 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manager Brass And Copper Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic to John Rvan Ellen Crosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Tract Road Fairfield, Pennsylvania 17320 Dennis Ryan/ son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date cemetery, crematory or other place)
Metro Crematory, Inc. 10/26/2012 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faciliteremation Society of Maryland, Inc. Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death , the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes Z No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work?

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director.

Medical State

Accident

Suicide

4 Homicide

29a. Certifier

(Check

only one

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) Physician/ KIVEra Davia Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9143 Old Scaggsville Road Howard Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Director 067-54-3381 1 X M 2 □ F 49 Puerto Rico Nov. 1, 1962 f and 2 should be filed within 72 hours enver-f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28a-f show Item 27 is marked other then "natural", or Items 25e or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9143 Old Scaggsville Road 20723 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces¹ Black, White, etc. 1 Never Married 2 X Married ģ Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 Y Yes 2 □ No Specify: Puerto Rico 3 🗌 Widowed 4 🗎 Divorced Specify: Hispanic Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carmel Anna Jiminez Rivera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9143 Old Scaggsville Rd., Laurel, Maryland 20723 Donna Rivera / Wife Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1 a Department of I Important: If Ite any Injury or of 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc :10/29/2012 Baltimore, Maryland 21. Signature of Euneral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Inc Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Ent. the disease, or complications that caused shock, or heart failure. List only one cause on each line ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ on disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed nding physicien end use es the burial-trensit resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Box 68760 ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month ed by the e 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The lew requires t within 24 hours after death.

To the Funeral Director: After this certificate hes been sign completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate hes ral director, page 2 autopsy death? 2 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 P Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The discretishing in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of fertifie of death (Item 23a) (Type, ROB 69 0

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle /Dast), 2. Date of Death Keisinaer Physician/ Mar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice @ Northwest Hospital Baltimore Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8 Date of Birth Days (Month, Day, Year) Director 214-18-7894 1 XM 2 □ F 91 Jan 7, 1921 Maryland Usual Residence of Deceder r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Marvland N/A Baltimore 1X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1621Ellamont Street 21230 **USA** 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No
If Yes, Give 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1955 Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Pege 1 and 2 should be filed within 72 Department of Health and Mental Hyglene, Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Mueller Edward L. Reisinger Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1621Ellamont Street Baltimore, Maryland 21230 Edward L. Reisinger III, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 0 10/30/12 injury o Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Thomas Gregor Name and Address of Facility Of Maryland, emation Society Of Maryland, 9 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death thrombos is Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day 5 Other (specify) Yes 2 □ No is certificate has been signed by the a director, page 2 should be detached 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 2 🗆 No 1 Tes Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence nospice 2 TO NO ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann f Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Mohith Lev Physician/ Lester Leonard Reich Medical 4a. Facility Name (if not institution, give street and number)
LOCK RUREN COMMUNITY LIV 4b. City, Town, or Location of Death 4c. County of Death Examiner LIVING Baltimore N/A If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth
(Month, Day, Year)
Sept 22, 1928 . Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Director 373-22-6951 1 👿 M 2 🗆 F Michigan 84 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other then "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Modical Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 996 Clausen Lane **USA** 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1949_1971 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other then " any injury or other traumatic event, the Mesone. Elementary/Secondary (0-12) College (1-4 or 5+) Communication Specialist Us Air Force Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 216 ဥ Reich Unk. Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21012 Cynthia L. Krankowski, daughter 996 Clausen Lane Arnold, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 10/31/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Socie 299 Frederick R ëty Of R**o**ad Inc. Marvland 21228 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sease ardio Vascul Immediate Cause (Final Atherosclevo Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 24 hours after death. • Funeral Director: After this certificate has been signed by the عالمات المعالمة المات الم 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25 Was case referred medical Be (26. Place of Death (Check only one) examiner? Other: 2 1 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 012 (Item 23ta) (Type, Print) Name and address of person aven icks Viimove

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State of Maryland /	Department of H Certificate of L			iene Reg. No. 201	2 34703						
			Registrar 1. Decedent's Name (First, Middle, Last)	3. Time of Death										
	Physicia Medic		Ellen Mary Rocks			Octob	er ^{Day} 25, ^Y 2	⁶ 012 1130ам						
)	Examin		4a. Facility Name (if not institution, give street and number) 1031 Phair Place		4c. County of Death Prince George's									
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 24	Year) 1937 Per	Birthplace (State or Foreign Country) nnsylvania						
	and show at	ا ة	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Location				10d. Inside City Limits						
	Maryla 28a-f otified	Director	MD Prince George's Laurel					1X Yes 2 □ No						
	s 23a or	Funeral D	1031 Phair Place	10f. Zip Code 20707			10g. Citizen of What USA	Country?						
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, Puerto		Black, W	merican Indian, Ihite, etc. White						
1215-0	thin 72 hou sne. than "natu ne Medical	Completed by	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+)	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of work	ing	16b. Kind of Business/Industry Education							
and 2	be filed wir ental Hygie ked other c event, the	ادہ ا	17. Father's Name (First, Middle, Last) Hugh Newman Rocks	Maiden Sumame) eth Foste	r									
Mary	12 should lith and Me 27 is mar r traumati			Zip Code)										
Baltimore, Maryland 21215-0036	Page 1 and ment of Hes ant: If item ury or othe			of Disposition (Name of lery, crematory or other place Journey Crem	1	Date / 28/12	20c. Location - City Woodbine,							
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الم	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non Hod kins Lymphoma Production (Program and Death Section 2)											
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	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cruse. Enter Undergray Cause (Disease or injury	of):										
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Вох	requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	f delivery Day Year										
ls, P.O.	uires that th signed by Ild be detac	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause gi	iven in Part I.			e to the cause of death?						
Division of Vital Records,	The law ate has page 2	Completed				24a. Was a autop perfor	osy prior	e autopsy findings available to completion of cause of h? Yes 2 □ No						
tall	i cian ; The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	Oth	Place of Death (Chec									
of Vi	Physic r this c eral dir	6: -12	1 Yes 2 € NO 1 Inpatient 2 ER/C 27. Manner of Death 28a. Date of injury 28b.	. Time of 28c. Inju	rv at		lence 6 Other (Some owinjury occurred	pecify)						
on c	ending eath. or: Afte he fun	ficat	1X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury wor M 1 L	rk? ☐ Yes 2 ☐ No									
Divisi	tal or Atters after de al Directo	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (S City or Tow		Rural Route Number,						
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director After this certification properlies of the funeral director, sompletely filled in by the funeral director,	Medical	29a. Certifier (Check conly one) 1 X Certifying Physician: To the best of my knowledge conly one) 3 Certifying Nurse Practitioner: To the best of my knowledge conly one) 3 Certifying Nurse Practitioner: To the best of my kn	d/or investigation, in my opin	ion, death occurred a	t the time, date a	nd place, and due to	the cause(s) and manner stated.						
	To the within 2 To the Complete		29b. Signature and title of certifier Powers & Reeds	29c. Licens D236			29d. Date signed (M October 20							
)			30. Name and address of person who completed cause of death (Item 23a) Edward Lee, M.D. 10710 Charter D.		olumbia. M	D 21044								
	Sta		31. Date filed (Month, Day, Year) 32. Degistrar's Signature	backer										
	Registr	ar	OCT 31 2012 June S.	garre										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 34704 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OcMobber 30ay 2012ar Physician/ ZaSu Lora Rommel 7:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oakcrest Care Center Parkville 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 213-38-6471 1 M 2 TF 92 Feb. 8, 1920 Maryland Vrs Usual Residence of Decedent items 23a or 28a-f shov 10b County 10c City Town or Location 10d. Inside City Limits Examiner must be notified at Director Parkville 1 Yes 2 X No Maryland Baltimore 10f Zin Code 10g. Citizen of What Country? 10e Street and Numbe Funeral USA 8830 Walther Blvd. Renaissance Gardens 21234 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. or i by 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 Divorced "natural", Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accounting Clerk Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4 or 5+) State of MD Be 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Pitts 17. Father's Name (First, Middle, Last) n and Mental I ೨ Jessie Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2703 Waldor Drive Parkville MD Department of Health a Important: If item 27 is any injury or other tra once. Charlotte Huber/ daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cemetery 1 XBurial 2 Cremation 3 Removal from State 11/3/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Leonard J. Ruck, 5305 Harford Road Inc. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebrovascular Disease Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician use as the IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 Month 2 No Ves g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementra 2 No 3 Probably 4 Unknown 1 Yes Should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d Describe how injury occurred Certificate: 1: Natural iniury work?
1 Yes 2 No 5 Pending Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Vertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

UCT 3 1 201

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8800 WW 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Marylan	d / Depa	artment of H	Health	and M	lental Hy		0.1.0	01705
			State Registrar			Cer	tificate of L	Death			Reg. No. 2	012	34705
	Physicia	in/	Decedent's Name (First, Middle	_						2. Date of De Month	eath		3. Time of Death
	Medic Examin	cal	Elmer 4a. Facility Name (if not institution	Lee		Raber	4b. City, Town, or	r I continu	a of Dooth	Octob	er 26,		9:40 AM
نر	Examili	iei	705 South Foun				Bel Air		TOI Death			ounty of Death rford	1
	Funeral		5. Social Security Number		Age (In yrs. la	st birthday)	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bi	th	g. Birtl	hplace (State or Foreign
	Director		215–42–8784 Usual Residence of Decedent	1 X M 2 □ F	69	Yrs.	I WOTHING Days	riodis	1	08/24/	1943		ryland
	and show	5	10a. State 10b. County		10c. City	, Town or Lo	cation					1	10d. Inside City Limits
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	h the	Funeral Director	10e. Street and Number		_		10f. Zip Code				_	n of What Co	untry?
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0	er dea or ite niner	by Fu	11. Marital Status 1 ☐ Never Married 2 【 X Mar	12. Was Deceder Armed Force 1X Yes 2			Vas Decedent of Hi FYes, specify Cuba	an, Mexica	an, Puerto I	city Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
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ם פר	e flied within 72 hours after death with the Maryland distributions. Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, I	Last)		10110	0111001		ther's Name	(First, Middle			
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Maryland 21215-0036	2 should th and M 27 is mar traumati		19a. Informant's Name/Relations Sharon D. Raber				g Address (Street a						cyland 21015
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Baltimore,			1 Burial 2X Cremation 4 Donation 5 Other (5			**	natory or other place rematory		~ 11/0	01/2012		-	Maryland
Salt	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Servi	icensee	,Du								and 21221
	00 = 00		23a. Part 1. Enter the disease, or	Compliantions About any								Maryl	
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BOX C	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live Birt 4 Pregnan	h 2 🗆 Fetal	death 3	Ectopic pregnanc	СУ			230	d. Date of deli Month	very Day Year
	y the ached	Physician/Me	1 Yes 2 No 9 Unknown	g Unknow		Jaur J	Other (specify)						
J.	requires that the deam certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by P	Part II. Other significant condition		h but not resu	Iting in the u	nderlying cause giv	en in Par	t I.	23e. Did t	obacco use	contribute to	the cause of death?
ds,	equires		TYPE II	Diabetes						1 🗆	Yes 2 🗌	No 3□Pro	obably 4 N Unknown
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Loonita	To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best	of my knowle	dge, death o	ccurred at the time	e, date an	d place, an	d due to the c	ause(s) and r	manner as sta	ited. ause(s) and manner stated.
tho th	ithin 2 the F	Me	only one) 3 Certifying 29b. Signature and the of certifier	Nurse Practitioner: To	the best of my	y knowledge,	death occurred at the	he time, d	late and place	ce, and due to	the cause(s) a	and manner as igned (Month,	stated.
P	- s F ō		Moderation	ha			D55		13			26 / 26	
			30. Name and address of person of KARL SPE	who completed cause or	f death (Item 2	23a) (Type, P	rint)	TE 12	D R	ELAN			
	Stat		31. Date filed (Month, Day, Year).					- 1	-5 D		- (
	Registra	ır	00131	2012 Cen	n p	. 14"							

DHMH 17 Hev 06-2511

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Elizabeth Matilda Rilev 2012 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 21, 1 Maryland Months Davs Hours 218-03-7224 Director 1 🗆 M 2 💥 F 91 1921 Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Treeway t Apt. 3B 21286 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XX No Specify white Specify: 3. Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) bookkeeper food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward Leroy Bigham Alice Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 15 Treeway Ct., Apt. 3B Towson, MD 21286 Patricia A. Livingston/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 29,2012 Baltimore, Maryland Metro Crematory Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney 200 E. Padonia Rd. Timonium, MD 21093 Valley, P. A 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition UBDUCA Medical resulting in death) Due to (or as a consequence of): ✓ Examiner Lacks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate 24 hours after death.

Funeral Director: After this certifica etely filled in by the funeral director. I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 D√yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) WS PUL ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural
2 Accident 5 Pending MULTILE FALLS 1 Yes 2 KNo MENOUN Investigation UNKINOWN Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Treeway CT , BA truck 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined nome BAI tomore M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation is provided in the cause of examination and/or investigation in the cause of examination and/or investigation is provided in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and or Medical 29a. Certifier **Sompletely** (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number OCTUSO 28 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST 31. Date filed (Month, Day, Ye State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth October 201[°]2 W. Rogers 2⁰2³ 4 :00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 200 Towsontown Ct apt 416
Social Security Number 6. Sex 7. / Towson Baltimore Year If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 9/21/1926 Days Hours Min. Director 220-24-1785 1 □ M 2XXF Yrs 86 Maryland Usual Residence of Decede ir then "natural", or items 23a or 28a-f show the Modest Evenings must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 200 Towsontown Ct apt 416 21204 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Technician (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacy permit. Page 1 and 2 should be filed w Department of Heelth and Mental Hygi Importent: if item 27 is marked other eny injury or other treumetic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wanicek Barbara Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Campion / daughter 1824 Hanford Road Rosedale, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp. 20c. Location - City or Town, State 1 Burial 2 D Cremation 3 Removal from State 10/31/2012 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of FacilitRuck Towson Funeral Home, Inc. . Signature of Funeral Service Lie 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Card emic disease or condition 0 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami nding physicien end use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed 24 hours after death. that initiated events Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physicien stuneral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 Who
9 Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital 유 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year) 303 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)

OCT 3 1 2012

32. Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month KOSS 3:15 am Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Ba Itimore Social Security Number . Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Hours Min. (Month, Day, Year) Director 1 M 2 F Yrs. MD ir than "natural", or items 23e or 28a-f show the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No ģ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hyglene. Important: If them 27 is marked other than 'eny injury or other traumetic event, the Magnee. condary (0-12) College (1-4 or 5+) Nursing Home Be 17, Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) should be ava Carter 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hubbard daughted 25202 Balto. MD Page 1 end 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Liou 70 Fredhilton Pass Ballo mp 21229 23a. Part 1. Jet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Charlote 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 🗆 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 5 No 1 Inpatient 2 ER/Outpatient 3 DOA Hardice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury Natural
Accident
Suicide
Homicide 5 \square Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2. Registrar's Sig Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Estelle Gloria Remez 2012 12:15 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8100 Connecticut Avenue, Chevy Chase Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Director 029-09-0909 1 🗆 M 2 🗶 F 92 01/08/1920 Usual Residence of Decede Massachusetts 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Florida Bay Panama City 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 367 Wahoo Road 32411 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1943—
If Yes, Give 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 1945 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Federal Government Be 17. Father's Name (First, Middle, Last) permit. Page 1 end 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any liury or other traumattc even once. 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Gilman Sarah Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shereen G. Remez - Daughter 8910 Honeybee Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory: 10/30/2012 Brentwood, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each life. 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Weeks Immediate Cause (Final disease or condition Physician Ruptured Aortic Aneurysm Medical resulting in death) Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Examiner Due to (or as a consequence of) Hospital or Attending Physician. The law requires that the death certificate be executed.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No
9 Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 X☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Senior |2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 2 Acciden 3 Suicide 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D11441 October 25, 2012 1541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Richard D. Schubert, 3301 New Mexico Avenue, #348, Washington, DC 20016

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 12:05PM^M 2012 October 0 Barbara Ann Ravas Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) Country) Director 182-38-3718 1 □ M 2 💢 F 65 1947 31, Usual Residence of Decedent <u>Pennsylvania</u> 10d. Inside City Limits 10c. City, Town or Location ir than "natural", or Itams 23a or 28a-f sho the Modical Examiner must be notified at 72 hours after death with the Maryland Director 1 Yes 2 No Montgomery Village <u>Maryland</u> Montgomery 10g. Citizen of What Country? 10e. Street and Number Funeral 20886 United States 9100 Bakerhill Court 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Specify. Specify. If Yes, Give 3 - Widowed 4 - Divorced Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filad within 72 Department of Health and Mental Hygiane. Important: If itam 27 is marked other than any injury or other traumatic evant, the Me National Institutes of Health Elementary/Secondary (0-12) College (1-4 or 5+) 12 Program Analyst Be 18. Mother's Name (First, Middle, Maiden Surname, Maryland 17. Father's Name (First, Middle, Last) Antoinette M. Gentile <u>John Joseph Hilyard</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9100 Bakerhill Court Montgomery Village, Maryland 20886 19a. Informant's Name/Relationship (Type, Print) Theodore E. Ravas, Jr./Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State November 3, 2012 Germantown, Maryland All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 . Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final breast concer Physician/ chronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Unduriving Cause (Disease or injury law requires that the death certificate be executed this certificate has been signed by the attending physician and rrai director, page 2 should be detached for usa as the burlal-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a, Was an performed? or Attanding Physician: Tha 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 🛱 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA hin 24 hours aftar death.
the Funaral Diractor: After this
mpletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complex only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 67258 October 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nicholas Farrell, MD 9707 Medital center Drive, Rockville, Mongland 20850 31. Date filed (Month, Day, Year) OCT 30 32. Registrar's Signature State 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER VERA E. REELING 2012 12:10 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 215-40-1611 Director 1 M 2 XF 90 3/7/1922 UNITED KINGDOM il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD BALTIMORE NOTTINGHAM 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4102 TAYLOR AVENUE APT. 211 21236 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 XWidowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ELEMENTARY SCHOOL 12TH GRADE AFETERIA WORKER Be 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot jury or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) UNAVAILABLE UNAVAILABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8618 LAWRENCE HILL RD. PERRY HALL, MD 21128 RUSSELL REELING/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or MORELAND MEM. PARK 10/31/2012 HILLENDALE, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lice 22. Name and Address of Facility MO1139 THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD NJO 23a/Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final troke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS CL 1 ☐ Yes 2 🕅 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined building, etc. (Specify) Hospital Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAMILES 6701 1/10 31. Date filed (Month, Day, Year) State 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month P M Samking Edward 201 Α. Medical October 5:41 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Country) Director 578-17-3113 1 🔀 M 2 🗆 F 52 June 22,1960 Sierra Leone show or than "natural", or Items 23a or 28e-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11556 Lockwood Drive #D-1 20904 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black. White, etc. Š 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12yrs <u>Hotel Worker</u> Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Should be file h and Mental F 7 is marked of ဥ traumatic Musa Samking Watta Jeneba Momoh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 14929 Ashford Court Laurel, Jeneba Samking/Daughter MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
eny injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/03/2012 Silver Spring, MD 21. Signature of Eurieral Solvice Licenses J.B. Jenkins Funeral Home, 22. Name and Address of Facility 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death
☐ 5 ☐ Career Grant State of the state IF FEMALE: 23b. Was decedent pregnant Box 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 5 ☐ Other (specify) Day 1 Yes 2 No ed by the a detached 1 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed to page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, CVA 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HTN 24a, Was an autopsy performed? Yes 2 XN or Attending Physician: The certificate DAD 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one, Be examiner? 2 No Other: ဂ္ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0072148 October 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, MD 20910 Allen Silfee 31. Date filed (Month, Day, Year) State 31 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	f Maryland	-	irtment of tificate of		and Me		Reg. No.	2012	34713		
	sician. edica	/	George	Speig	inte				2	2. Date of Dea Month	Day	Year 2012	3. Time of Death 7:50 PM		
Abs.	edica		a. Facility Name (if not institution, g	live street and numi	ber)		4b. City, Town,	IMO	RE			ounty of Death			
Fune Direc		5	213-30-2204	1 X M 2 □ F	7. Age (In yrs. Ia 79	st birthday) Yrs.	If Under 1 Year Months Day			B. Date of Birtl (Month, Day 07-31-	h v, Year) •33	9. Birthp Coun	place (State or Foreign try) MD		
aryland a-f show	fled at	ector	Usual Residence of Decedent 10a. State 10b. County MD N			Town or Local						1	0d. Inside City Limits 1 Yes 2 □ No		
with the Mi	ist be not	Funeral Director	Oe. Street and Number 2807 Round Roa				10f. Zip Code	.225			10g. Citize	en of What Cour	ntry?		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou	Examiner mu	2	1. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	Armed For	Э		Vas Decedent o Yes, specify Cu			fy Yes or No- can, etc.)		4. Race - Americ Black, White, pecify: Ame1	etc. African		
21215-0036 within 72 hours after giene.	Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		4 or 5+)	(Give	lent's Usual Occ dind of work dor O NOT use retire	e during mo	st of working	7	16b. Kind of Business/Industry				
ST P Ind 21.	event, the	e l	9th Grade 17. Father's Name (First, Middle, La		1		Labo	18. Mot		First, Middle,	Maiden Su				
Maryland 2 should be filed th and Mental Hy 27 is marked out	raumatic	2	George 19a. Informant's Name/Relationshi		nts		Edna Mi 19b. Mailing Address (Street and Number or Rural Route Number, City o 2807 Round Road Baltimore, Mary								
lore, N ge 1 and 2 it of Health	or other tr		Marlene Speigh 20a. Method of Disposition 1XXBurial 2 □ Cremation	3 ☐ Removal from	State C	lace of Dispo emetery, crer	sition (Name of natory or other p	olace)	Da	ite	20c. Loc	ation - City or T	own, State		
Baltimore,	any injury			Cremation 3 Removal from State Mt. Zion Cemetery 10-27-12 Lansdowne, MD											
3			23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final	ily one cause on ea	ch line.	n. Do not ent	er the mode of o					c, ridly	Approximate Interval Between Onset and Death		
Physic Med Exam	lical		disease or condition resulting in death)	a. Ey	or as a consequ		.thy Renal	Di ce	ale						
uted	ransıt	Examiner	b. Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
760 ate be executed	he burial-t	edical Ey	resulting in death) Last	Due to	or as a consequ	uence of):									
SLOVAL S PLIGHT ision of Vital Records, P.O. Box 687(attending Physician: The law requires that the death certifica ar death.		Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🗌 Live	come of pregna Birth 2 Feta nant at time of a	al death 3	Ectopic pregr				2	3d. Date of deli	very Day Year		
ords, P.O.	be detac	by Ph	Part II. Other significant condition		eath but not res	sulting in the	underlying cause	given in Pa	rt I.				the cause of death?		
られてのよ of Vital Records, ig Physician: The law requires ter this certificate has been sig	ige 2 should	mpletec									opsy ormed?	prior to c death?	opsy findings available ompletion of cause of		
5&OVG. Vital Reconvision: The law not certificate has be	lirector, pa	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatie		- · ·	eath (Check	only one)	2 No	Other (Special			
β L O Y O Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha	the funeral c	Certificate: To	27. Manner of Death 1	28a. Date (Mon ation	of injury th, Day, Year)	28b. Time o injury	f 28c. I	njury at vork? Yes 2	□ No	8d. Describe	how injury	occurred	al Route Number,		
Division oital or Attendin urs after death. eral Director: Aft	illed in by		4 Homicide determi	28e. Place	e of Injury - At ho ing, etc. (Specify	/) 				City or To	wn, State)				
o the Hosp ithin 24 ho	ompletely	Medical	(Chook 2 Medical E	xaminer: On the ba	eie of examination	n and/or inve	stigation, in my o	pinion, death	occurred at date and place	the time, date	and place, the cause(and due to the c	ause(s) and manner stat s stated.		
1 5 ≥ 5	ŏ		> Ponouru	-	My	-	7	357	5			10 25	12		
5 V	Ctat		30. Name and address of person of Bhownest 31. Date filed (Month, Day, Year)	Bharaj	8 8 7 3 Registrar's Signa	ature (Type,	Print) altha	m	WDOO	ls rd	<u>+</u>	artevil	le MD 212		
Re	Stat gistra		0CT 3 1	2012	inva	1. 1	harres				<u></u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07/6 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number 014401 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** sept T, Year) 922 1 □ M 2 🛚 F Days Hours Min. Maryland 90 219-12-4427 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director notified 1 X Yes 2 No Brevard Rockledge FL10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò must be USA Funeral 32955 23a 989 Woodsmere Parkway permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
1f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Addressograph Operator Financial Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ည Bessie Dennis Walter Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 989 Woodsmere Parkway Rockledge, FL 32955 19a. Informant's Name/Relationship (Type, Print) Gloria J. Reed/POA/Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 10/26/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatus of Funeral Service Lice Going Home Cremation Service P.O.Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Stage Onset and Death End Immediate Cause (Final domentica Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗀 Yes 2 🗀 No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မှ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work' 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of bortifier October 25 2012

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

3 1 2012

lease	ype or Print in Black indelible ink. Ensure All Copies Are L	-'
	State of Manyland / Department of Health and Mental Hygiene	

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Georganne Schm	•	Sirver State	tate of Mary	land / Depa Ce	artment o <i>rtificate o</i> i	f Health and F <i>Death</i>	d Mental		20 eg. No.	12 34/15	
Physicia		t egistrar 1. Decedent's Name (First, Midd	lle,Last)					2. Date of Dea Month		3. Time of Death	
Medical Examin	er	Georganne Schminky October 25, 2012									
() () () () () () () () () ()		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Fort Washington Medical Center 4c. County of Death Fort Washington Prince George's									
Funeral	4	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		Irs. 8. Date of Bi	th(MM/DD/YYYY)	9. Birthplace (State or	
Director		413-96-4427	1 M 2XF	58	Yrs	Months Days	Hours N	Nov 2	1, 1953	Foreign Country) Tennessee	
		Usual Residence of Decedent								10d. Inside City Limits	
w any	1	10a. State 10b. County	e George'	1 1	, Town or Local t Washi					1 Yes 2 X No	
yland t-f sho	핡	MD Prince		5 101	- Washin	10f. Zip Code		1	0g. Citizen of Wha	at Country?	
	Dire	11615 Kimberly	y Woods L	ane		20744			USA		
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ours aff	d b	15. Decedent's Education (Spe	or Dates:			nt's Usual Occupat			16b. Kind of Bus	iness/Industry	
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OO3 withingiene.	Ē.	12 17. Father's Name (First, Middle	e, Last)		Tionicatio		18.Mother's Na	me (First, Middle,	Maiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	George Spence	ר				Lois Ar				
MD 21 d 2 should th and Me n 27 is ma numatic ev	리	19a. Informant's Name/Relation James A. Schm.		and	19b. Mailin	g Address (Stree Kimberl	y Woods	or Rural Route Nu S Lane Ft	mber, City or Towr Washin	n, State, Zip Code) ngton, MD 20744	
Te, M 1 and 2 Health Fitem 2		20a. Method of Disposition 1 Burial 2 X Crematic		20b.	Place of Dispo crematory or o	sition (Name of cer ther place)	netery,	Date	20c. Location -	City or Town, State	
Baltimore, pernit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S		Fi	nal Jou	rney Cre	matory	10/28/12	Woodbi	ne, MD	
Salti ermit. Separtn mport		21 Signature of Funeral Service			GC GC	Name and Address DING HOME	Cremat	tion Serv	vice P.C	Box 784	
Physician	-	23a, Part I. E. ifer the disease, of	or complications that	MO1	h. Do not enter	verly L the most of dying,	Heckrof such as cardia	hte PA. acorr spiratory an	rest, shock, or hea	rille MD 21029 art pproximate Interval Between Onset and	
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Examiner		or condition resulting in death)		s a consequence	of):						
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D. B. lat the d d by the etached	, Physic	Part II. Other significant cond	itions contribution	g to death but not	resulting in the	underlying cause	given in Part I.			ibute to the cause of death?	
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ital Re(ician: The certificate	æ	25. Was case referred to media examiner?		Inpatient 2	ER/Outpatier		Other No	ursing Home 5	Residence 6	Other:	
of Vil ing Physic After this	P	1 ✓ Yes 2 No 27. Manner of Death	28a. D	ate of Injury	28b. Time of		ry at Work?	28d. Describe	how injury occurr		
ion (tending eath.	tion			onth, Day,Year) 10–24–12	fd 14:	21 pm 1	Yes 2 🗶 No	DOOL		into swimming	
Division Hospital or Attendii 24 hours after death. Funeral Director: A	Certification:	3 Suicide 6 Co	uld not be 28e. F		home, farm, str	eet, factory, office	building, etc.	or Town,	State)11615	er or Rural Route Number, City Kimberly Woods	
Di- ospital ospital ospital y filled	S	4 Homicide	termined (Speci Physician: To the	пош		urred at the time of	ate and place	Ln. F	<u>ort Wash</u>	ington,MD.	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	edical		caminer: On the ba	sis of examination	and/or investig	ation, in my opinio	n, death occurr	red at the time, dat	e and place, and o	due to the cause(s)	
To vitt	Mec	29b. Signature and title of certi	and mann fier	ci stateu.		29c. Licen	se number			ed (Month, Day, Year)	
		Theolen 1	U. K.	of JRu	mid	0.0	.M.E.	OGME	October 26	5, 2012	
A-		30. Name and address of pers Theodore M. King, J		se of dear (It	m 23a) Examiner	900 W. Balti	more Street	t, Baltimore, N	1D 21223		
	ate		·	Registrar's Signa				-,			
Regist		OCT 3 1	2012	enous ,	d. pa	100					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Grace Margaret Smith 2012 4:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 242-38-0091 Director 1 🗆 M 2 🔀 F 83 Yrs. 01/21/1929 West Virginia 27 is merked other than "netural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location daath with tha Maryland 10d. Inside City Limits Directo Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Strut Court 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give within 72 hours aftar ፩ Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry parmit. Paga 1 and 2 should ba filed within 72: Department of Health and Mental Hygiana. Important: If tem 27 is merked other than "ne any injury or other traumatic event and once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher's Aid Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ John Thomas Reid Ida Bessie Eller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Sue Herlihy (Daughter) 500 Kilarney Court, Forest Hill, Maryland 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. 10/27/2012 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.

1407 old Factorn Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the chief of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immente Cause (Final Physician/ ase or condition ATRIAL FIBRILLATION Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Mospitel or Attending Physician: Tha law raquiras that tha daath cartificata be axecuted within 24 hours aftar death.

To the Funeral Director: Aftar this cartificata has baen signad by the attanding physician and complataly fillad in by tha funaral diractor, paga 2 should ba detachad for use as tha burial-transli that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE ည 1 Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗆 No Investigation 6 Could not be ☐ Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🖹 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

TRACIE L.

MORGAN,

CRNP

4:20

2012

25,

OCTOBER

SMITH

VALLEY RD.

TIMONIUM, MD 21093

2300 DULANEY

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 1 per doc, 17,19a per fh g933 11-7-12 vt
State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30. RODNEY GILBERT STEIFF Rodney Gilbert Stieff 8:40A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Towson Baltimore Blakehurst Care Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8 Date of Birth Days Hours Min (Month, Day, Year) Director 212-28-4361 87 Yrs 04/03/1925 Maryland Usual Residence of Deced or than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X Yo Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 West Joppa Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? WXX Yes 2 □ No WW I I If Yes, Give 1 Never Married XX Married ⋛ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiane. Elementary/Secondary (0-12) College (1-4 or 5+) President Silver Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should ba file and Mantal H 2 Gideon Numsen Steiff Stieff Claire vonMarees 19a. Informant's Name/Relationship (78t fieff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Paga 1 and 2 shi Dapartmant of Haath an Important: If Item 27 is any injury or other traui Wife Dorothea Stedman Steiff 1055 West Joppa Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial XXX Cremation 3 Removal from State Donation 5 Other (Specify) Metro Crematory 10/31/2012 |Baltimore, Maryland nature of Funeral 22. Name and Address of FacMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of ad by the attanding physician and datached for use as tha burlal-transit Hospital or Attending Physician: Tha law raquiras that tha death cartificata ba axacuted that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Pregnant at time of death g Unknown within 24 hours aftar daath. To the Funeral Director: After this cartificata has baen signad by t completaly fillad in by tha funeral diractor, paga 2 should ba datach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💆 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) ure and title of certifier 29d. Date signed (Month, Day, Year) cepelle tho completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) State Registrar

10/26/12 0500A Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barbara Jane Strong October 2012 Medical 5:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Funeral Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 479-34-3343 1 □ M 2 🕱 F 79 Mar. 9, 1933 Iowa show "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 962 Redfield Road Apt. A 21014 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. 12 Food Server Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Mervin W. Mongold Princess Patricia Wren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin L. Strong / 1232 Graver Lane, Chesapeake, VA 23322 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill 10-29-2012 Svcs. Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month 5 Other (specify) Dav Year 1 Yes 2 No Pregnant at time of death director, page 2 should be detached g 🗌 Unknown signed by Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 🗌 Yes 2 No ■Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) (10) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

3 1 2012

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:08 AM **Physician** SPURRIER OCTOBER 25 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min: 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Yrs 87 Jan. 2,1925 Maryland Director 218-12-8177 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 1 Yes 2 No Director Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 23a or 1949 Codd Avenue must be United States 21222 Funeral rraf", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes Ar No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: <u>ک</u> ier than "natural", c 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within rent of Health and Mental Hygiene. nt: If item 27 is marked other than " College (1-4 or 5+) Elementary/Secondary (0-12) marked other than Homemaker Own Home 12 Years 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Edith Arnold Arthur Pugh Whittle Dorothy မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise D. Spurrier (Daughter) 1949 Codd Avenue Dundalk, Maryland 21222 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1x Bunal 2 ☐ Cremation 14/01/2012 Donation 5 Other (Specify) Gardens of Faith Cem. Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service License Denni⁄s Carrol/1 7922 Wise Ave. Dundalk, Maryland 23a. Fart +. Emer the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respirator Approximate Interval Between Onset and Death IMBALANCE Immediate Cause (Final disease or condition resulting in death) ECTROL **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) EPSIS physician and s the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Tyes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury M 1 Yes 2 No death. Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State)

Box 68760¢ P.O. Records, Division of Vital or Attending filled in by Hospital 24 hours

State

Registrar

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

park

within 2

Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

5-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

25,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ne Lee Shind		State State	of Maryland / L		ent of He ate of De		ientai riy		201	2 34720
Dhuaicic		Registrar 1. Decedent's Name (First, Middle,Les)	Ochino	10 01 00	-	1	Reg. 2. Date of Death		3. Time of Death
Physicia dical Exami		DIANE LEE	,	SHIN	DLER		14	Month October 24,	ay Year 2012	1538 hrs
		4a. Facility Name (if not institution, give		D1122.	4b. Ci	ty, Town, or Loca	tion of Death		4c. County of Deat	h
		5841 Wyndham Circle #20				lumbia		Ta hi kantat	Howard O. Bi	thulana (Ctata or
Funeral		Social Security Number 6. Security Number	7. Age (1	n yrs. last birt			Under 24Hrs. Hours Min.	1	MM/DD/YYYY) 9. Bir Forei	gn
Director		022-42-6613	M 2XF	60	Yrs.			12/04/	1951	ountry) MA
b		Usual Residence of Decedent 10a, State 10b. County	110	c. City. Town	or Location					10d. Inside City Limits
ow any										1 Yes 2 No
vfaryland 28a-f sbow d at once.	흱	MD HOWARD 10e, Street and Number	L.	COLO	MBIA 10f	Zip Code		10g	. Citizen of What Cou	intry?
th the Maryland 23a or 28a-f sho notified at once.	Director		DCIE #206			2104	4		USA	
vith th s 23a	<u>a</u>	5841 WYNDHAM CI	12. Was Decedent Ev	er in U.S.	13. Was De	edent of Hispanie	c Origin? (Spe	ecify Yes or No-		rican Indian, Black,
eath v item	Funeral	1 Never Married 2 Married	Armed Forces?	No	If Yes, s	pecify Cuban, Me	xican, Pueπo i	Rican, etc.)	White, etc.	
fter d	by Fi		If Yes, Give Year or Dates			2 No sp				WHITE
ours a	8	15. Decedent's Education (Specify or	- Production of the second		Decedent's Useduring most of	sual Dccupation (working life. DO	Give kind of w NOT use retire	0111 00110	6b. Kind of Business	rindustry
6 n 72 h	jet	Elementary/Secondary (0-12)	College (1-4 or 5+)		T TNTCA	L SOCIAL	MODKE	D I	MENTAL H	EALTH
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21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the <u>Medica</u>	BeC	ABRAHAM		SHINDLE	ER	I	LILLIAN			RASLOW
212 Suld bould bound mari	To E	19a. Informant's Name/Relationship (7		19	b. Mailing Add				er, City or Town, Stat	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Healint and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury o: other traumatic event, the Medical Examiner must be notified at once.		GAIL FELDMAN/SI	STER					D, COLUN	IBIA, MD 20c. Location - City of	21044
re, s 1 and f Heal ff item		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	crema	tory or other p				•	
Pager Pager nent o		4 Donation 5 Other Specify		COLUM	MBIA ME	MORIAL I	PK 10/2	6/2012	COLUMBI	
Baltimore, permit. Pages 1 ar Department of He Important: If ite		21. Signature of Funeral Service Licer	nsee			and Address of F			SON & BROS	
		23a. Part I, Enter the disease, or com	plications that caused th	e death. Do n	ot enter than	KEISIEL ode of dying, such	h as cardiac or	respiratory erres	IKESVILLE, st, shock, or heart	Approximate Interval
Physician Medical		failure. List only one cause on e	ach line.							Between Onset and Death
Examiner		Immediate Cause (Final disease a or condition resulting in death)	Hanging Due to (or as a consequence)	uence of):						
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):						
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O, be executed rician and burial - transit	ᄪ									
O, be execut sician and	edical	UNPENDED	AMENDED						23d. Date of delive	ary are
Box 68760, a death certificate be the attending physic ed for use as the bur	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		y 2 Fetal o	eath 3 E	Ectopic pregna	incy	Month	Day Year
x 68 h certi tendin use a	<u> </u>	past 12 months?	4 Pregnant at til			(Specify)				Į
Bo e deat the at	Physician/M	1 Yes 2 No 9 V Unknow	0 01010	nut mot requiti	na in the unde	rlying cause giver	n in Part I	23e. Did tob	pacco use contribute t	to the cause of death?
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IS, F quires en sign ald be							-	24a. Was a		autopsy findings available
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of V Phys ter thi eral di	<u>유</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury FOUND:		. Time of Injur	/ 28c. Injury a	it Work?		ow injury occurred	
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Division tal or Attendin rs after death. al Director: /	- E	2 Accident Investigat 3 Suicide 6 Could no	28e Place of Init.			actory, office build	ding, etc.	28f. Location (S or Town, St	treet and Number or ate)	Rural Route Number, City
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.		(Direct Only	clan: To the best of my er:On the basis of exam	knowledge, d	leath occurred	at the time, date	and place, and	due to the cause at the time, date a	e(s) and manner as si and place, and due to	tated. the cause(s)
To the Hot within 24 h To the Fui	Medical		and manner stated.	mation and/o		29c. License n			29d. Date signed (I	
	Σ	29b. Signature and title of certifier	Dag			O.C.M.			October 25, 20	
		Toulle-	79KK	ath (Itam 22a		<u></u>			L	
		30. Name and address of person who Patricia Aronica-Pollak M		edical Exa	miner 90	0 W. Baltimo	re Street, l	Baltimore, MI	21223	
	 State	31. Date filed (Month, Day, Year)	82. Registrar	s Signature	4					
	stra	0 0 004	2 Rever	1. 4	barker					

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SNYDER 11:15AM DAVID OCTOBET Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death RAHPALLSTOWN NORTHWEST HOSPITAL BALTIMORE ocial Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days Hours (Month, Day, Year) Director 217-06-3975 1 XM 2 □ F 09/12/1971 MD Usual Residence of Decedent shov 10c. City, Town or Location within 72 hours after death with the Maryland or than "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 TNo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 807 HOPEWOOD ROAD 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 SALES SALES it. Page 1 and 2 should be filed wit theert of Health and Mental Hygier trant: If item 27 is marked other i jury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ STUART **SNYDER** MARYETTE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STUART SNYDER/FATHER 4001 WINLEE ROAD, RANDALLSTOWN, t of Healt : If item : / or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PK. 10/28/2012 REISTERSTOWN, MD 21. Signature of Pineral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ENCEPHALOPATHY ANOXIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SPAG OVERDOSE DRUG Sequentially list conditions, Examine If any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequency of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Day 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 1 🗌 Yes 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause of 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 EP/Outpatient 3 DOA After this 24 hours after death.

Funeral Director: After this letely filled in by the funeral of Certificate: 27. Manner of Death Date of injury
(Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Coc. dev ta] 28c. Injury at 1 Natural
2 Accident 5 Pending unknowNM 1 ☐ Yes 2 No overdase 10/23/2012 Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Toy Town, State) 4 Homicide determined OME Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certificial Number Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) D0060293 30. Name and addr ted cause of death (Item 23a) (Type, Print) COURT RD. RANDALLSTOWN OLD 31. Date filed (Month, Day, OCT 3 State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ TO12 Month PATMICIA SCHOU 245 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROM WELL BALTI MORE CENTER BALTIMONE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F Hours 697731934 78 577-48-6772 WASHINGTON DC Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits death with the Maryland 10c. City. Town or Location notified at Director 1 Yes 2 No MD BALTIMORE BALDWIN 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Examiner must be Funeral 23a USA 4901 SWEET AIR ROAD 21013 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 12 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "1 traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12TH GRADE HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumating once. ည ANN CUNNINGHAM JAMES A. HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALDWIN, MD J. RICARD SCHOU/STEP SON 4901 SWEET AIR ROAD more, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) CATONSVILLE, MD 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 10/27/2012 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Signatury of Funeral Service Lio MO1137 TOWSON, MD 8521 LOCH RAVEN BLVD. 21286 high 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARRHYTAMIA Onset and Death Immediate Cause (Final CARDIAE Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CAN TO MYO PATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): WIMES ASCVI or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed page 2 certificate Yes 2 No rision of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death week only one) Be examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1- Natural death. 2 Accident
3 Suicide Investigation 24 hours after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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FERNANDO 31. Date filed (Month, Day, Year)



29c. License number

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29d. Date signed (Month, Day, Year)

10/261

BALTIMONE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Theodore 2012 8:15PM Aurora Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville P.G. 2021 Patterson Street 8. Date of Birth (Month, Day, Ye. 2-18-2 Social Security Number . Age (In vrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Min. 1 🗆 M 2 🔀 Hours Trinidad 91 Director 579-94-1072 Usual Residence of Decedent show or 28a-f show notified at filed within 72 hours after death with the Maryland al Hygiene. 3 other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Hyattsville P.G. MD. 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or Funeral U.S.A. 20782 2021 Patterson Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Housewife Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) ပ Isabella Jordan Henry Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 2021 Patterson St. Hyattsville, Md. Frances Theodore/Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/10/12 4 Donation 5 Other (Specify) Riverdale, Md. Riverdale Park Name and Address of Facility
Hackett's Funeral Chapel, Signatu f Funeral Service Licens W. 814 Upshur Street, NW art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ zheimers unknown disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the a Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2K XN0 1 Inpatient 2 ER/Outpatient 3 DOA 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 Ves 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title

of certifier

Lippman,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

M.D. 1801 McCormick Dr. Largo, Md. 20774

D25001

Oct. 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:22 AM Anna Lee Turner 10 5 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A Birthplace (State or Foreign Country)

__ If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 02/20/1946 245-86-7369 Director 1 □ M 2 🖾 F N.C. 66Yrs. Usual Residence of Decedent in than "naturel", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Directo MD N/A Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 533 N. Longwood Street 10f. Zip Code 10g. Citizen of What Country? USA 21223 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates Black 1 ☐ Yes 2 X No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N.M. Carroll Manor Reception 12 e 1 and 2 should be filed with of Health end Mental Hygie If item 27 Is marked other in other treumatic event, It Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Jones, Sr. Maggie Tann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Health er Important: if item 27 Is eny Injury or other treu Verna Jones-Munthal 533 N. Longwood St. Balto. MD 21223 (Dahtr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from State 126/12 Baltimore, MD On-Site Crematory 10 4 Donation 5 Other (Specify) 22. Name and Address of Facility
JOSeph H. Brown Jr.
2140 N. Fulton Ave. gnatur of Funeral Avvice Lic Funeral Balto., 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death only months Physician Anoxic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Ventricular Caro Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physiclan: The law requires that the death certificate be executed hypertensive attending physician and I for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate hes been signed funeral director, page 2 should be de Š Records, 1 Yes Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🖭 No မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kaleu 2438946 10/25/12

2

State Registrar 31. Date filed (Month, Day, Year)

OCT 3 1 2012

DARABEA

SHAHEEN 201 East University park way, Baltimorp, MD21218

Server Signature

Server Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	me Adiotella Loca		f Maryla		artment of H		Mental Hyg	eg. No.	2	3 4 7 2 5	
	Physici /Medio		1. Decedent's Name (Fir	sı, middie, Last	1	HOMP	SON			Month	Day	Year ZOIZ	1015 A M	
Ì	Examir		4a. Facility Name (If not 314 Upperla					4b. City, Town, or			4c. County	of Death Balti	more	
	Funeral		5. Social Security Number	er 6. Se	×	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 H				lace (State or Foreign	
	Director		219 18 9898 Usual Residence of Dec		X M 2□F	87	Yrs.	Worth's Days	Tiodis III	Sept.17	,1925		aryland	
	ryland how		10a. State 10b	. County		10c. 0	City, Town or Lo	cation				1	Od. Inside City Limits	
	the Ma	Director	Maryland Ba	altimore	e 		Esse	10f. Zip Code			Og. Citizen of V	Vhat Cour	1 ☐ Yes 2 No	
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036	72 hours efter death with the Maryland 'natural', or Iteme 23a or 28e-f ehow digal Examinar must be notilised at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □		12. Was Dece Armed Fo 1 X Yes If Yes, Giv Year or Da	rces? 2 No e WW	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? n, Mexican, Put Specify:	(Specify Yes or No- erto Rican, etc.)	Blac	e - Americ k, White, : Whi	etc.	
21215-0036	within 72 ane. then "nai	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4					dent's Usual Occupi kind of work done of DO NOT use retired	during most of w	rorking	16b. Kind of Bu		lustry	
nd	be filed tal Hygie d other event, II	Be	17. Father's Name (First		The same of					ame (First, Middle,	Maiden Sumam	ιθ)		
Maryland	should nd Men marks matic	2	Charles Fre			OH	19b. Mailir	ng Address (Street		Guiher Rural Route Number	r, City or Town,	State, Zip	Code)	
	12. har 7 is treu		Veronica Tho							Baltimore				
Baltimore,	permit. Pages 1 end Department of Healt Important: If Item 2 any Injury or other once.		20a. Method of Dispositi 1X Burial 2 Cro 4 Donation 5	emation 3 🗆 F		State	. Stani:	natory or other places slaus Ceme	etery 10	/27/2012				
Balt	permit. Depart Import any inj		21. Signature of Funera	Service Licens	wske		22 E 1	Name and Address Rruzdzinsl 407 Old l	s of Facility Ki Fune: Eastern	ral Home I Avenue Es	P.A. Ssex, Ma	aryla	nd 21221	
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8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list condition in any, leading to immediate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	liate	c. Dl	or as a conse or as a conse	equence oi):						6 YEARS	
.O. Box 6	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day		
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									bacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 ▼Unknown		
I Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed	DISEASE 24a. Was an autopsy performed? 1 Yes 2 Who								sy med?	Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of	
Vital	iclen: certific rector,	Be	25. Was case referred to examiner?	1	Hospital:			Oth	or	eath (Check only or				
of		atlon: To	1 Yes 2 No 27. Manner of Death 1. Natural 5	☐ Pending investigation									v)	
Division	Hospitel or Attending 24 hours efter death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural R City or Town, State)			nl Route Number,		
	To the Hospitel or Within 24 hours effe To the Funerel Dir completely filled in	edical	29a. Certifier 12 (Check only 2 one)	Certifying Phy Medical Exam	iner: On the ba	best of my k asis of exami ner stated.	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the courred at the time, o	ause(s) and ma late and place,	anner as s and due to	tated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title	of certifier	1	/		29c. Licens	e number	2	29d. Date signe	d (Month,	Day, Year)	
2			In	for t	ton	h	MD		2032		OCTOBE	225	5,2012	
			30. Name and Iddress of	1			em 23a) (Type, HOPKIN:	Print) S BAYVI	W CIP	T.E BAT	TO.,MD	212	24	
	Sta Registi		31. Date filed (Month, D		-32 B	egistrar's Sig				LALL UALL	4 V + 7 171D	612	24	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician/ Month Barbara Thrush 15: 21 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of manyland medical cente Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 06/22/1941 71 216-40-1835 **Director** 1 M 2 X F MD Usual Residence of Decedent 28a-f show 10d, Inside City Limits ms 23a or 28a-f shor must be notified at 10b. County 10c. City, Town or Location 10a. State Director Glen Burnie Anne Arundel 1 Yes 2 X No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8122 Phirne Road East 21061 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Innportant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) B.G.E. Legal Secretary 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Kathryn Swetz George Dinko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Husband 8122 Phirne Road East Glen Burnie, MD Charles F. Thrush, Jr., 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Michael's Cem 11/5/2012 Dundalk, MD 4 Donation 5 Other (Specify) 21. Signature of Funerati Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, 21229 4107 Wilkens Avenue Baltimore, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Septicemia Medical Due to or as a consequence of): Examiner ulamia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Data to for as a consequence of: Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown the a been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural After injury 5 Pending 1 Yes 2 No of thours after death.

Funeral Director: As sletely filled in by the full Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

22 S. Greene St. Baltimore, MD , MP

Lauren Halvorson 31. Date filed (Month, Day, Year) **OCT 3 1 2012** 32. Registrar's Signature parker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hai

M.D.

1871818328

10/27/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201^{Yea} October 0 11:50 PM James T. Tippett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye May 11, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 D F North Carolina 1931 239-40-4460 Director 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland| Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 301 Russell Avenue United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Computer Security U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Glennie Tippett Birdie Kinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Tippett Forsythe / Daughter 6078 Piney Woods Court, Alexandria, VA 22315 20b. Place of Disposition (Name of October 2012 20c. Location - City or Town, State Montgomery or other place) Crematorium, Inc. 1 \square Burial 2 X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Sign ture VFU et a service Lo M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ neumon disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner cirales Sequentially list conditions, if any, leading to immediate Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death 9 Unknown Unknown Division of Vital Records, P.O. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has e 2 performed ide 2 🗌 No certificate Yes 1 Yes 25. Wa case referred t Be edical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 M No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar 31. Date filed (Month, Day, Year)

H. Hohert Berschline

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/RUSSEAL

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

04113

24ber 26,20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 27, 2012 5:15 P.M MARY JOSEPHINE TRACY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS NURSING HOME TIMONIUM BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Mir Director 275**-**01**-**7543 1 □ M 2🗶 F 95 3/19/1917 OHIO Usual Residence of Deced 28a-f shov 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No PARKVILLE BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 ASHFORD ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME 12TH GRADE HOMEMAKER permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If Item 27 is marked other amy injury or other traumatic event, ti once. Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROY RAUSCH AGNES MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA FLEISCHMANN/DAUGHTER 8820 ASHFORD ROAD PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OCTOBER 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) METRO CREMATORY, INC. 10/30/2012 4 Donation 5 Other (Specify) CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. pice Lin nsee MO1139 Signatury of Funeral Se 8521 LOCH RAVEN BLVD TOWSON. MD Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MYELODYSPLASIA Completed 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? TF CY 24a. Was an autopsy perform 2 🗌 No Yes 1 Tyes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Nature. Accident 5 Pending work?
1 ☐ Yes 2 ☐ No after death Investigation filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier R 043580 Leis CRN 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) laney Valley Rd., Timonium. MD 21093 2300 32. Registrar's Signature State Registrar X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bruce Donald Vennell 2012 8:45 p M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Howard Columbia If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Dec 30, 1957 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours New Jersey Director 1 M 2 D F 195-52-8734 54 Yrs. 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglane.
ant: If item 27 ie merked other then "neture!", or items 23e or 28e-f shoungs or other treumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location Be Completed by Funeral Director 10d. Inside City Limits Butler PA Butler 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 116 Sunburst Court 16001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1.2 College (1-4 or 5+) Maintenance Engineer Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald Vennell Marilyn Bowersox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Vennell/son 3100 McNeal Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 10/26/12 Department of Important: If eny Injury or pnce. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer GGillig Holles Challation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MO1251 MD 21029 23a. Part 1. Enter the disease, or conshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death MELANOMA Physician/ MALIGNANT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-trensit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 🗷 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 📈 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 1/ Natural 2 Accident 5 Pending Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fittle of ce ress of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA ABBAS MD CEDAR LANE 31. Date filed (Mont 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October 24, 2012 6:55 P_M Ruth Volz Doris Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Baltimore Lutherville Stella Maris If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 04/27/1921 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Maryland Director 216-12-8865 1 M 2 X F 91 Usual Residence of Deceden or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Monte I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔼 No Baltimore Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21221 830 Sue Grove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black. White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: White 3 🛛 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Mitchell Wirt Randall Arnold, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1949 Sue Creek Drive, Baltimore, Maryland 21221 John Joseph Volz (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 10/29/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.A. Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Screen Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships, or heart failure. List only one cause on each line. Interval Between Onset and Death Immaniate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events burlal-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 👿 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

DORIS VOLZ

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar 34731 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milton Woeh1ke 2012 George October 26 11:18 pм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charlestown Retirement Community Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Maryland Months (Month, Day ar 31 1 X M 2 □ F Days Hours Min. 220-18-9428 **Director** 86 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Catonsville Maryland Baltimore 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code ıral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 21228 715 Maiden Choice Lane, PV612 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: "natural" 3 Divorced 4 Divorced Specify White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Master Electrician Electrical Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leonard Gerald Woeh1ke Edith Sommers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 st Department of Health a Important; If item 27 is any Injury or other trau Susan Woehlke / Wife 715 Maiden Choice Ln., PV612, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/29/2012 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician/ Metastatic prostate concer disease or condition resulting in death) ears Medical Examiner Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the Least of my knowledge, Snoth accounted at the three, date and place, and due to the 29d. Date signed (Month, Day, Year) D30989 October 28 2012 ress of person who completed cause of death (Item 23a) (Type, Print) 711 Maidon Choice Ln Catonoville MD 21228

Registrar

NOahlka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM# 4a, per PHYS, G932, IU/31/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arthur Lee Willis, Jr. 10 21 2012 8:12 a^M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1641 Aisquith Street N/A Baltimore N/A Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral X**M 2 □ F Days Months Hours Min. 03/08/1947 218-46-6005 65 Yrs. Director MD Usual Residence of Decedent 28a-f show 10a, State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1641 Aisquith Street 21202 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc à 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Laborer Local Union 194 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Lee Willis, Sr. Zelphia Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1641 Aisquith St. Baltimore, MD 21202 Vanessa Willis (Wife) Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 25 On-Site Crematory 4 Donation 5 Other (Specify) Baltimore, MD Joseph Fail Brown Jr. 2140 N. Fulton Ave. Signature of uneral Servi Funeral Home PA Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After 1 Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work?
1 Yes 2 No fter death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) kenzs R125808 10/24/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRND SAC 4109 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Sharon Jane Woo 2. Date of Death 3. Time of Death Month OCTOBE Woods Sharon Physician/ 0230 AM Medical 4c. County of Death N/A4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES BALTIMURE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Oct. 16, 1946 Min New Jersey Months Days Hours 140-44-2141 1 🗆 M 2 🛣 F Director 66 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director Prince William Manassas Virginia XX Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20110 9507 FairviewAvenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Malden Surname) June McColleick 17. Father's Name (First, Middle, Last) မ Fred Cronce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
36 Overbrook Road Catonsville MD 21228 19a. Informant's Name/Relationship (Type, Print) Bonnie Woods/Daughter Date 20c. Location - City or Town, State 10/27/2012Alexandria Twp. NJ 20a. Method of Disposition 20b. Place of Disposition (Name of Mcemetery crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Leonard ddgs okuck, 5305 Harford Road Inc. Baltimore MD Vi E 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CELLMUITIS BACTERIAL Unknown PERITONITIS Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or injury a years filled in by the funeral director, page 2 should be detached for use as the burial-transit CANCER STAGE The law requires that the death certificate be executed OVARIAN and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death SHARON 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed death? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 1 Matural 5 \square Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 [29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier hichter P2548 DCT. 24, 2012

Do My

31. Date filed (Month, Day, Year)

OCT 3 1 2012

August 4.

CALATA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

ST. AGNES HOSPITAL

MARYLAND

BALTIMURE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Merdis M. White Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Dito 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 248-70-0689 Director 1 □ M 2 🔀 F 12/08/1941 71 Yrs. S. Carolina I end 2 should be filed within 72 hours efter death with the Meryland f Heelih end Mentel Hyghen.

Fileseth end Seath Hyghen.

The marked other then "neturel", or thems 23e or 28e-f show other treumetic event, the Medical Exemples must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2633 Marbourne Avenue 21230 USA 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Private Homes 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eddie McCutcheon Angeline Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy White (Husband) 2633 Marbourne Ave. Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Date Pege 1 1 ABurial 2 Cremation 3 Removal from State Injury 4 Donation 5 Other (Specify) Cedar Hill 11/2/12 Brooklyn Pk., MD 21. Signiture of Ferrora Source Licensee, 22. Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave. any Ir Funeral Home PA Balto., MD 21217 disease, or complica Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest nock, or heaft failure. List only on mediate Cause (Final d sease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence Cause (Disease or injury that initiated events resulting in death) Last tor: After this certificate has been signed by the ettending physicien end the funeral director, page 2 should be detached for use as the buriel-tren Due to (or as a consequence of) Physician/Medical it or Attending Physicien: The lew requires thet the death certificate be a siter death.

Director: After this certificate hes been signed by the ettending physicie Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner Death Certificate; 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be To the Hospitat or Atte within 24 hours effer de To the Funerel Directo completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marner as stated. only one 29b. Signature and 29d. Date signed (Month, Day, Year)

OCTOBER 73, 2012 who completed cause of death (Item 23a) (Type, Print)

Met 9 % Co-F 30. Name and addre 7 31. Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Month Morris Willard Wagner October 8:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Senator Bob Hooper House Forest Hill Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Min. (Month, Day, Year) Director 219-30-2334 1X M 2 | F 82 June 6, 1930 Pennsylvania Usual Residence of Dece 28e-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 XNo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai items 23e 3614 Old Level Road 21078 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 X Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: if item 27 is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Heavy Equipment Operator County Government Be Filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Clinton G. Wagner Elizabeth Willard Heckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 end 2 Anna V. Wagner / Wife 3614 Old Level Road, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) Bel Air Memorial Gdn 11-1-12 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. lessico diverve 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SOPHA GEAL Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Incorrying Cause (Disease or injury Examine Due to (or as a consequence of): attending physicien and I for use as the burial-transit or Attending Physicien: The lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day cate has been signed by the a page 2 should be detached g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physicien: The lew within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed? 1 Yes 2 🗌 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 뎯 1 🗆 Yes 2 X No Other:
4 Nursing Home 5 Residence 6 Other (Speeds) 1 Inpatient 2 ER/Outpatient 3 DOA MO LEY. 27. Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and of death (Item 23a) (Type, Print) 7300 DUL State 31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 October 26, 6:15 A Franziska Rosa Williamson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Apt. 318 Bel Air 300 Sunflower Dr. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Dav. Year) Months Days Hours Director 215-42-9397 1 M 2 X F 85 Apr. 2, 1927 Austria Usual Residence of Decedent artment of Health and Mental Hygiene. nortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Harford Maryland Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 21014 USA 300 Sunflower Dr. Apt. 318 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※No If Yes, Give 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker Williamson Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Marie (unk) Krauftner Franz (unk) Vanek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once. Kristine A. Laing / Daughter 8550 Southwest 85th St., Trenton, FL 32693 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition TANZISKA ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 10-29-12 Bel Air, Maryland Rose Hill Svcs. LLC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onget and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Disk to for as a nonsective policific Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death signed by the ar 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed? pertension 1 Yes 2 No 25. Was case e erred to medical examiner?

1 Yes 2 No funeral director. 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

State Registrar (Check

only one

29b. Signature and title of certifier

32. Registrar's Month, Day, Year

Name and address of person who completed cause of death (Item 23a) (Type, Print

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month Day, Year)

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Linda Kay Weaver	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2012	3473
Physician/ Medical Examiner	Month Day Year	ime of Death 648 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3107 Good Hope Avenue 4c. County of Death Temple Hills Prince George's	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace	ce (State or
Director	577-72-6425 1 M 2 X F 59 Yrs. Will July 11, 1953 Country)	Indiana
v any		. Inside City Limits
yland n-f shov t once.	Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Yes 2 X No
the Maryland a nr 28a-f sh tiffied at once		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", nr items 23a nr 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc.	ndian, Black,
s after der ral", nr i niner mu by Fu	3 vidowed 4 Divorced in res, cive real 1 Yes 2 No specify: Specify: WILLCE	
2 hours "natur	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indust during most of working life. DO NOT use retired) 16b. Kind of Business/Indust Motor Vehic.	
5-0036 ed within 72 hour offer then "natu the Medical Exau Completed	4 Clerk Administrat	ion
215-C be filed v ntal Hygi rked othi cnt, the		
221; hould bend and Men is marl	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (
e, Mi	Virginia W. Feitz / Sister 1121 West Elm Terrace, Olathe, Kansas 660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town	
Pages Pages nent of ant: If	1	ryland
Balti permit. Departu Impurt	21. Sivnature of Funeral Septice Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Depth A. Pumphrey Funeral Home / Rockville Inc., 300 West Montgomery Avenue, Rockville, Maryland 20	ბგნი
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App	proximate Interval etween Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Death
_	Sequentially list conditions.	
ted I Insit Examiner	Course Error Underlying Course (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):	
cuted and transit	events resulting in death) Last Due to (or as a consequence or): d.	
60, te be executed nysician and burial - transit	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
6876 ertificat iding phi e as the		Year
). Box 68760, the death certificate be the death certificate be by the attending physic ched for use as the burn Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	
P.O. s that the	1 Yes 2 No 3 Probably	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	24a. Was an 24b. Were autopsy autopsy prior to comple	findings available
Reco The law cate has page 2 s	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
fital sician: is certifilirector, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?	ne
n of Vi ing Physi After this funeral dir on: To	27 Manner of Death 28a Deta of Injury 28b Time of Injury 28c Injury at Work 2 28d Describe how injury occurred	
ision Attend or death. rectur: by the i	Natural 5 Pending 1 Yes 2 No Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Ro	oute Number, City
Division o opital or Attending hours after death neral Director: Aft rilled in by the fune Certification:	Suicide 6 Could not be determined (Specify)	. ,
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E		se(s)
To with To com		ay, Year)
	30. Name and address of person who completed cause of death attem 23a)	
D	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KATHERINE DOROTHY YOUNGER OCT 2012 1:30PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CITIZENS NURSING HOME HAVRE de GRACE **HARFORD** Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 20, 1922 **Funeral** Birthplace (State or Foreign Country) Hours 212-50-3182 **Director** 1 M 2 X F 90 MD. Yrs Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Harford Edgewood 1 Yes 2x No 10e. Street and Number r items 23a or iner must be n 10f. Zip Code 5 10g. Citizen of What Country? Funeral 1917 Stevens Dr. 21040 USA ı "natural", or item ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. XX Widowed 4 Divorced Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) event, the 12 vrs N/A Housewife Housekeeping-Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 1 and 2 should be find Health and Mental ပ Earl Lee Jackson Anna Bauerfrend traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1917 Stevens Drive Edgewood, Md. David W. Younger (Son) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 10-29-2012 Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Servi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions Examine Dusi to (or se's noneequence by cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical requires that the death certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 19 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? å A be Division of Vital Records, Completed 1 Yes 2 No 3 Probably Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an or Attending Physician: The law has page 2 certificate 25. Was ease referred to medical examiner? Be Place of Death (Check only one) ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA this Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 ature and title

am

State Registrar

State 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of	Maryland /	/ Department	of Healt	h and	Mental	Hygiene

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	Property	-	 Page	-		-	

Vernon Gilbert An	1	SON - For State Registrar	State	of Maryla		partmen Certificate			d Ment	tal Hyg		eg. No.	20	12	3473
Physician Medical Examina	n/ er	1. Decedent's Name (Firs		VER		GILBEI		ANDERS			Date of Dea Month October 1	Day 6, 201			3. Time of Death 1425 hrs
		4a. Facility Name (if not i 1603 Rockhold		ve street and nur	nber)		4b	. City, Town, or I Edgewater	Location o	of Death		1	County of I		
Funeral		5. Social Security Number	r 6. S	ex	7. Age (In y	rs. last birthda	y)	If Under 1 Year			8. Date of Bir	rth (MM/D		9. Birth	place (State or
Director	_ L	216 80 30		M 2 F	5	52	Yrs.	Months Days	Hours	Min.	04 07	19		Cour	ntry)
ku w		Usual Residence of Dece 10a. State 10b.	County		10c. (City, Town or L	ocatio	n							10d. Inside City Limits
2	۱۵	MD A	nne A	rundel	Cł	nurcht	on								1 Yes 2 No
r 28a-f	Director	10e. Street and Number						10f. Zip Code			1	0g. Citize	en of What		
s 23a o		5605 Esse	ex St	12. Was Dec	edent Ever i	in U.S. 13	. Was	Decedent of Hisp	207 panic Orig		cify Yes or No)- 1	U.S 14. Race - A		an Indian, Black,
death v	Funeral	1 Never Married 2	_	1 Yes	2 X N			s, specify Cuban,		, Puerto Ri	ican, etc.)		White,	etc.	
rs after ural",	잙	3 Widowed 4 15. Decedent's Education		d If Yes, Give Year or Dates:				res 2 No		kind of wo	rk done		Specify: ind of Busir		nite
72 hour		Elementary/Secondary		College (1				t of working life.				105.14			,
5-0036 led within 7 Hygiene.	Completed	10	Middle Lee			Au	to	Mechar	nic	la Nama (F	First, Middle.		utom	oti	.ve
	ပ် ရှိ	17. Father's Name (First,	Middle, Las		r Try	ving A	nd	erson			,			er]	and
21; hould b nd Men is mar	2	19a. Informant's Name/R		Type, Print)		19b. M	ailing /	Address (Street	t and Num	ber or Ru	ral Route Nur	nber, Cit	y or Town,	State, 2	Zip Code)
h, MD and 2 sho lealth and 2 tem 27 is traumati		Robert And 20a. Method of Disposition		n – So				D Junip on (Name of cen	per	St.	Ft. Date	Dix 20c. L	ocation - C	ity or T	0 8 6 4 0 own, State
Baltimore, permit. Pages I ar Department of Het Important: If ite	- 1	1 Burial 2 Cr			om State	crematory Bavvie		rplace) Cremato	orv	10/	19/12	B	alti	mor	e. MD
Caltin		4 Donation 5 C 21. Signat						me and Address							Iome, PA
	4	23a. Part I. Enter the dise	ase or com	plications that ca	sused the de	eath. Do not er		9 Rivie					ena,		21122 Approximate Interval
Physician Medical		failure. List only one	cause on e												Between Onset and Death
Examiner		or condition resulting in o	leath)	Due to (or as a			пс	IHLUXIC	ation					\neg	
	<u>ē</u>	Sequentially list condition if any, leading to immediate	ate	Due to (or as a	consequen	ce of):								\neg	
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5876 prtificat ding phy as the	2	IF FEMALE: 23b. Was decedent pregn past 12 months?	ant in the	23c. If yes, o	irth	2	Feta	I death 3	Ectopio	pregnanc	су		i. Date of de Month	Da	ay Year
Box 68760 e death certificate b the attending physic cd for use as the bu	Physician/Me	1 Yes 2 No 9	Unknow		ant at time o	of death 5	Othe	er (Specify)				Ì			2
, P.O. Box 68760, res that the death certificate be signed by the attending physici be detached for use as the burn	된	Part II. Other significant	conditions	contributing to	death but r	not resulting in	the un	derlying cause g	iven in Pa	art I.				_	ne cause of death?
LS, P quires then signed and be d			_								1 Ye				bly 4 Unknown
COTC law reshaber	Completed										autoj perfo	psy ormed?	pride:	or to co ath?	mpletion of cause of
of Vital Records, ig Physician: The law require. The this certificate has been so neral director, page 2 should in the control of the control		25. Was case referred to	medical		-			26.Place	of Death	(Check on	1 Yes	2 No) 1	y Yes	2 No
this ce	o Be	examiner? 1 ✓ Yes 2	No	Hospital: 1 I	npatient 2								nce 6 🗸		Scene
n of Vil	• • II	27. Manner of Death 1 Natural 5	Pending		Day, Year)	28b. Tim		100	ryatWork ∕es 2 🗶	.	28d. Describe Inknowi		ry occurred	1	
Division tal or Attendi rs after death. al Director: A led in by the fi	licati	2 Accident	Investiga Could no	280 Place	of Injury -		street	J pm factory, office b	uilding, et		8f Location (Street ar	nd Number	or Rur	al Route Number, City
Div ospital o hours aff nneral Di y filled i	Certification	4 Homicide	determin		S	ingle F	'ami	1y Home		E	dgewat	er,	1D.		old Rd.
e Ho c Fu	हु			clan: To the bes er:On the basis o	of examinati										
To wit	Medi	29b. Signature and title of	f certifier	and manner s	tated.			29c. License	e number			29d. D)ate signed	d (Mon	th, Day, Year)
		Panielly	ricka	4 m				0.0.1	M.E.			Octo	ober 17,	2012	
		30. Name and address o		•			900	W. Baltimore	e Street	t, Baltim	ore, MD 2	21223			
Sta	te	31. Date filed (Month, Da			gistrar's Sig										
Registr		OCT 3	0 2012	Serve	-	1. pa	do								
DHMH 17 Rev 1/200	J1					ÖRIG	INAL					00	CARE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34740 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert G. Austin Month 10 Day 29 1710 Medical give street and number 4a. Facility Name (if not institution, Examiner 4b. City. Town, or Location of Death 4c. County of Death Universit of Maryland Baltimore Cit If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Hours **Director** 218-34-1793 1 XM 2 🗆 F 73 April 23, 1939 Virginia Usual Residence of Dece 28a-f show 10a. State 10b County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland 1 Yes 2 XNo Harford Darlington ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1940 Franklin Church Road 21034 United States 12. Was Decedent Ever in U.S. items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1962.

1 Yes 2 No 1964

If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify:White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) the Computer Technician Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Unknown traumatic Siddie Alma Austin Department of Health and Important: If item 27 is n any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Treva Austin / Wife 1940 Franklin Church Road, Darlington, MD 21034 Nov. Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel Bel Air 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 2012 4 ☐ Donatjon 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature Funeral Service Cicerses Evans Fuleral Chapel & 3 Newport Drive Forest Cremation Service-BelAir Hill, MAryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CERTIFICATION REPROVED BY MEDICAL ECOMINER shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Examiner 98daus Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury renal Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial awnmower accident Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Yes Hospital 2 🗆 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending lawnmower vallover 07/23/12 1 Yes 2 No Investigation 1600 M 28f. Location (Street and Number or Rural Route Sumber Indian 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, et (Specify) 1940 Franklin Church Rd. NLD 21034 nome Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ST Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) October 29, 2012 R107416 wx1

Registrar DHMH 17 Rev 06-2011

State

22 S. Greene Street Baltimore

MD

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0 | 2 34741 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Glenda B. Albaugh October 26,2012 ar 10:04 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign May 31, 1927 214-22-4379 Days Hours Director 1 □ M 2 1 F Pennsylvania 85 Yrs. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 6008 Mannington Avenue USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates white 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Department of Teachers Aide Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Genevieve Steele George Edward Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 Mannington Avenue—Baltimore, Maryland 21206 Hiram Norman Albaugh-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) partment of F portant: if ite 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State injury or Parkwood Cemetery Nov.3,2012 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departn
Importa
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 indrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Immediate Cause (Final Onset and Death Physician/ Angiosarcom A CUTANCOUS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and I for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day 1 Yes 21 9 Hospital or Attending Physician: The law requires that the deal 24 hours after death.
9 Funeral Director: After this certificate has been signed by the a letely filled in by the funeral director, page 2 should be detached. 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 200 **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) \bowtie 5 ρ \bowtie ٩ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number aurm OCTUSE 27 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAron ST TOWSON MO CHMIES w 31. Date filed (Month, Day, Year) 22. Registrar's Signature State NOV 0 1 201 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Physician/ 2350 Alston Yvonne, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MARYLANDMEDICALCENTE OF 8. Date of Birth (Mdnth, Pay, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In vrs **Funeral** Hours Director 6 28a-f show 10d. Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Completed by Funeral Director 1 Yes 2 ☐ No altimore MD 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2√ No 1 Nes 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ollege (1-4 or 5+) Elementary/Secondary (0-12) ustomer Years Be Ather's Name (First, Mid 2 20b. Place of Dispositio ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signal re of Fune al Service Licensee Part 1. Enter the disease, or complications that caused shock, or head ailure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter Interval Between Onset and Death Immediate Cause (Final disease or condition CARDIAL ARREST "Chysician/ Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day been signed by the atter should be detached for I Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown ASTHMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Hospital 2 No 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 5 Pending injury 1. Natural Investigation Accident 3 ☐ Suicide 4 ☐ Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of 1447526298 10, 30, 2012 riddence, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 BALTIMORE, MD SOUTH GREENE ST SIDDIQUE 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Armshong For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ x tobes 357 M Mary F. Armstrong 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITUL Dinai Bultimare Bultimere Mary 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Min (Month, Day, Year) Hours Director 1 M 2 X F July 2, 1940 Maryland 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

14 the 21st and Mental Hygiene "natural", or items 23a or 28a-f show item 27st marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 11√2 Yes 2 □ No 25 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Roland Avenue #509 Funeral 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: white Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) July 1 and 2 should be Jupartment of Health and Mental Important: If item 27 is more any injury or other 2000. William Geoge Shannon Ida Snierman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital Belvedere AVenue Baltimore. MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature Fruneral Service Licensee Stare and Address of Facility and 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Dater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ with metastatic carcinoma mall cell disease or condition Medical resulting in death) Due to (or as a consequence of): August Zoll Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami ettending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death ed by the e 9 Unknown 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, The law requires 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending injury death, 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check mpleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State NOV 0 1 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 6:00p 2012 tkins 10 6 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Gilchirst Hospice lowson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min (Month, Day, Year) 215-70-2799 Director 1 M 2 XF 28 04 59 53 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10b Count with the Maryland Director 1 Yes 2 No Baltimore Randallstown 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral 21133 U.S.A. 9033 Samoset Roac death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1/2 Never Married 2 ☐ Mamied 1 ☐ Yes 2 🛣 No If Yes, Give Š hours after Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 | and Mental Hygiene. College (1-4 or 5+ Elementary/Secondary (0-12) Social Security Adm. 12th grade Claims Authorizer na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eunice Williams Charles D. Atkins permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1425 Kitmore Road, Baltimore, Md Danner Livingston-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 11/3/2012 Woodlawn, Synature of Funeral Service acens March fin West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ Bladde ance disease or condition Sugar. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin-Due to (or as a consequence of) Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be 68760 the as IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown be detached the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş Yes 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖎 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) al or Attending Ph s after death. Il Director: After th 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at 1) Natural
2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No e Hospital or Attendir 24 hours after death. e Funeral Director: Af bletely filled in by the fu Investigation 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Medical The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License numbe and title of certifie 29b. Signature 27 2012 $\sim\sim$ OCTUBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIES 701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:45AM BIVA n row 10 -Medical -2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Iree Managomer Sprinc 7. Age (In yrs. last birthday) If Under 24 Hr **Funeral** 8. Date of Birth 9. Birthplac State or Foreign 1 ₺ M 2 🗆 F (Month, Day Hours 40 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Silver Spring M 10e. Street and Numbe 10f. Zip Sode 10g. Citizen of What Country? united-States 14216 Dear 30906 items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 Never Married 2 Married Black, White, etc. ò Completed by 1 Yes 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify BIACK 3 Divorced "natural" Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) of Health and Mental Hitem 27 is marked of other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) of Funeral Service Name and Address of Fallity Howell Funeral Home Heights Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mone of dying, s. ch as ca 📲 ac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause E. ter Underlying Cause (Disease or iinjury Examine the burial-transit that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 ası IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Vear 2 🗌 No signed by the aid be detached for 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner 1/2 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Te the best of my lipswiedge, deathid at the time, date and place, and due to the cauca(e) and main or so stated 29b. Signature and title of certifier 29c. License number ipleted cause of death (Item 3a) (Type, Print) # AZ64 4000 Mitchville DR. Kimberly Borgie, Maryking 32. Registrar's Signature State 1 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a-d, per md g935 12/6/12 trt
State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Howard Joseph Bollinger, Jr 0923 aM 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ROSEDALE SQUARE MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Maryland 218-54-3429 Director 56 Yrs. 1 💢 M 2 🗆 F Jan. 25, 1956 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Rosedale Baltimore MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 1824 Wilhelm Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. by 1 Never Married 2 Married Yes 2X No Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Firefighter 12 Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shirley Lillian Wagner Howard Joseph Bollinger, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1824 Wilhelm Avenue-Rosedale, Maryland 21237 Shirley Bollinger-spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Chapel Nov. 3, 2012 and Cranation Ser. Belair 1 Burial 2 K Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Cardiogenic Shock & Cardiopulmonary Arrest Onset and Death Physician/ disease or condition Medical resulting in death) Examiner SHOCK STEMI Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Esophageal Cancer (terminal) with metastasis burial-transi Cause (Disease or injury that initiated events RECENT ST SECMENT ELEVATION MYCCARDIAN INFARCTION attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 CARDICP JEMENARY 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 2 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Hospital: ၉ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 \square Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sydernala 29 12 KES9000 30. Name and address of person who complet ed cause of death (Item 23a) (Type, Print) VARIWALA 4000 FRANKLIN DR RUCHITA SOUARE DR BALTIMORE 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** Ctobe 201 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 77 Aug. 02, 1935 Baltimore, Maryland 216-34-3912 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Show or 28a-f shov notified at 1 Yes 2X No **Baltimore** Maryland **Baltimore County** Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number r items 23a or iner must be n ö 21222 United States 7808 Charclesmont Road Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S.
Armed Forces?

1 Xeys 2 No Anny
If Yes, Give
Year or Dates Peace Time 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 21215-0036 ö White Specify: 3 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) r than the ₩ Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehen Steel 03 Engineer 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be 27 is marked c traumatic eve Anna Kupanski. Bernard Andrew Backert ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7808 Charlesmont Road Baltimore, Maryland Department of Health a Important: If item 27 is any Injury or other tra Mrs. Lorraine E. Backert (Wife) 20b. Place of Disposition (Name of 20a. Method of Disposition ation - City or lown, State (**Harricad County**) **Tuesday** 1 Burial 2 Cremation 3 Removal from State Evans Funetal Chapel and Forest Hill, Maryland Oct. 30, 2012 4 ☐ Donation 5 ☐ Other (Specify) Cremation Services, Inc. Oct. 30, 2012 Forest Hill, Maryland

Jeffrey L.Gair, Sr. O.S.P. Name and Address of Facility

Penceful Alternatives Funeral and Cremation Center, P.A. 21. Signatu 21093-2215 2325 York Road Timonium, Maryland Lic.#M00677 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate nterval Between Onset and Death Cardia Immediate Cause (Final **Physician** C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 151 Sequentially list conditions, if any lower sequence is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor s a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death Ectopic pregnancy 1 Live birth Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Hospital: Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death. Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No М filled in by the Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C i ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Certified RES-000 October 27,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 2 Mes 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 11595 NOV 0 1

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Eleanor Bonhage October 26, 2012 7:30 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County 819 Loyola Drive Towson 8. Date of Birth (Month, Day, . Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 215-40-0937 72 **Director** 1 🗌 M 2**X** F Baltimore, MD. Feb. 12, 1940 or 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🔀No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funera 21204 United States 819 Loyola Drive death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 Yes 2 XNo Specify: White If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) National permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) Kidney Foundation Director of Patient Serv 12 04 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Elmer Schmidt Della Pruitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr.Robert E. Bonhage (Husband) 819 Loyola Drive Towson, Maryland 21204 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Monday (Harford County)
Foest Hill, Maryland Evars Fureral Crapel and Cremation Services, Inc. Burial 2 ** Cremation 3 ** Removal from State any injury or Oct. 29, 2012 4 Donation 5 Other (Specify) Signature of Funeral Sergice Licensee Jeffrey L. Gair, Sr. Orsp. 22 Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A.

| April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | April | A mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Promisian/ disease or condition resulting in death) Medical or as a consequence of) Due to **Examiner** Sequentially list ponditio Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical P.O. Box 68760 the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnar 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav Pregnant at time of death signed by the a d be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Records. Completed peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Hospital or Attending Physician: The law page 2 has performed 2 No certificate 1 TYes Division of Vital 25. Was case referred to examiner? 26. Place of Death (Check only one) funeral director, Be 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 4 Nursing Home Residence 6 Other (Specify) ဂ္ဂ After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending Yes 2 No Investigation
6 Could not be within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) deta mined Medical 🗠 🇲 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (A . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Marita Eleene Beckles 2 0 1 2 2158 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Washington Adventist Hospital Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Year) 138-52-2003 **Director** 85 April 08,1927 Barbados Usual Residence of Decedent rai", or items 23e or 28e-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director St. Peter, Barbados, West Indies None. 1 Yes 2 X No Barbados 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. Batalleus None Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or δ 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Black Completed 3 Widowed 4 X Divorced The Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Engineer Plaza Hotel of NY permit. Page 1 and 2 should be fileo
Department of Health and Mental Hys,
importent: if item 27 is marked
eny injury or other **** injury or other treumetic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Naomi Bryan Christopher Deane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Beckles - Daughter 12009 Swallow Falls Ct., Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🕅 Burial 2 🗆 Cremation 3 🖾 Removal from State St. Peter's Cemetery 11/13/2012 St. Peter's, Barbados 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses MO1564 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ESPIRATURY DISTRESS SUNDRON Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner -ASTATIC ADENOCARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ettending physician and for use as the burial-tren that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SUNDROME ASTING Records, 2 No 3 Probably 4 Unknown PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifie 1 🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only 29b. Signate 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, Maryland 20912 Piotr Mikolas Wyrwinski, M.D., 31. Date filed (Month, Day, Year) NOV 0 1 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		**		Certificate of Death	Reg.	C U 1 E	34/50	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death	
	Medic	al	Lorraine 4a. Facility Name (if not institution, give street and number)	Bailey 4b. City, Town, or Location of Death	10. 7	29 2012 4c. County of Death	5:30a. [™]	
	Examin	er	Future Care Nursing Home	Baltimore		4c. County of Death		
	Funeral Director		5. Social Security Number 219-26-5941 6. Sex 1 M 2 X F 7. Age (In yrs. last birth) Y Usual Residence of Decedent	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea)	9. Birth Cour	place (State or Foreign http://	
	and show 1 at	or	10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits	
	Maryli 28a-f otifiec	Director		imore			1 X Yes 2 □ No	
	with the s 23a or ust be n	Funeral D	10e. Street and Number 3530 Resource Drive Apt 312	10f. Zip Code 21207	10g	. Citizen of What Could	*	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B		
Maryland 21215-0036	ithin 72 hou ene. • than "nati the Medica	Completed by	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) Clerk	ing 16	b. Kind of Business In		
and 2	be filed wight ental Hygic ked other ic event, t	Be	17. Father's Name (First, Middle, Last) Purnell Wilson Bailey	18. Mother's Nam	e (First, Middle, Maid Shields			
, Mary	d 2 should ealth and Me 27 is mar er traumati			Mailing Address (Street and Number or Run 60 East Northern	al Route Number, Cit Parkway	y or Town, State, Zip , Baltim	^{Code)} 21239 ore, Md	
Baltimore,	Page 1 an ment of He ant: If iten ury or othe		1 X Burial 2 □ Cremation 3 □ Removal from State cemetery 4 □ Donation 5 □ Other (Specify) King I	Disposition (Name of , crematory or other place) Memorial Park 11,		c. Location - City or To Woodlawn		
Balt	permit. Departi Import any inj		21. Signature of Futural Service Lines e	22. Name and Address of Facility March F/H West 4300 Wabash Ave	Baltim	ore, Md	21215	
- 4	nysician/	k Vi	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ot enter the mode of dying, such as cardiac	or respiratory arrest,		Approximatè Interval Between Onset and Death	
	Medical Examiner	Ļ	resulting in death) Due to (or as a consequence of Sequentially list conditions, b.	M				
_	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events C.					
760	icate be executed physician and s the burial-transi	edical E	resulting in death) Last Due to (or as a consequence of d):				
Box 687	eath certificate be executed attending physician and for use as the burial-transit	Physician/Meo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3		23d. Date of deliv	very Day Year	
P.O. B	hat the de ed by the detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to t	the cause of death?	
ds, l	quires 1 en sign	ted b			1 🗆 Yes	2 No 3 Pro	obably 4 Unknown	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after decental within 24 hours after decental or The the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Completed by			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of	
ta	Physician: T r this certifica aral director, p	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I postiont 2 ER/Out	26. Place of Death (Chec		· · · · · · · · · · · · · · · · · · ·		
on of \	nding Phy ath. :: After this e funeral d	icate: To	27. Manger of Death 28a. Date of injury 28b. Ti		28d. Describe how i	e 6 Other (Specifinjury occurred	<i>y</i>)	
Division	al or Attendir s after death. Il Director: Af ed in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fame building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	reet and Number or Rural Route Number, n, State)		
	he Hospit in 24 hour he Funera ipleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, decreased to the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and/or and the control of the basis of examination and the control of the control o	investigation, in my opinion, death occurred a	t the time, date and p	place, and due to the ca	ause(s) and manner stated.	
	North To t		29b. Signature and title of certifier	29c. License number	29d	Date signed (Month,	Day, Year)	
	4,		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) (4) 7 / 100/04/20 14.	Rank 1100	10-01	٠٤٦	
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	or while Au	Day) (rae	, VIAU		
	Registra	ar	NOV 0 1 2012 Person D. Sa	Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year MARY ELIZABETH 5:35 PM Medical 10 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE MEDSTAR GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Director 216-18-7859 RI 10 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits **Funeral Director** ☐ Yes 2 ☐ No BALTIMORE 10e. Street and Number Good Samaritan Nursing Ctr. 10f. Zip Code 10g. Citizen of What Country? USA E. Belvedere Ave. 21239 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "! Elementary/Secondary (0-12) College (1-4 or 5+) Convenience Store Retail Sales/Cashier/Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Ernest Lombardi Pasqualina Louise DeCola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Mr William P. Lombardi/brother 2508 Harthan Ct., Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/26/12 Glen Burnie, MD 21. Signatur 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final MULTIORGAN Physician/ FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 10 Yes 2 - No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar EHABSAADAWW -=

EHAB SAAD ALDIN

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

32. Registrar Signat

LOCH RAVEN

BALTIMORE

MD 21239

BLVD ,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2012 Virginia M. Baxter October 26, 6:45AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Taylor Farm Assisted Living Bushwood St. Mary's Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Director 245 36 2807 Usual Residence of Dec 1 - M 2 X F 84 May 19, 1928 show ms 23a or 28a-f sho must be notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 🗆 Yes 2 🔀 No Chantilly <u>Virginia</u> Fairfax 10f. Zip Code 10g. Citizen of What Country? Funeral with 13849 Constitution Court 20151 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Xes 2 No
If Xes, Give
Year or Dates. Black, White, etc. 0 Completed by 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced "natural" White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claude Brownell Marjorie Probasco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 13849 Constitution Court, Chamilly, Virginia 20151 Thomas L. Baxter (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. cemetery, crematory or other place, 1 Burial 2 XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 31, 2012 Clinton, MD Lee Crematory 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Signature 100155 Ferry Road. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events mentin Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 Alo Month Year Pregnant at time of death Day detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No page 2 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifie

Dana Russell 31. Date filed (Month, Day, Year)

41680 Ms Bessy Dr., Suite 301, Leonardtown, MD 20650

Ussell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician/ Gary T. Bruce 0935 CLM 2012 ic Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROSEDALE BALTIMORE FRANKLIN SQUARE MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Jan. 13, 1952 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Min 212-56-5772 Hours 1**X** M 2 □ F 60 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director r 28a-f sh notified a MD Baltimore Middle River 1 🗌 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ns 23a or must be r Funeral 21220 USA 26 Gyro Drive "natural", or items edical Examiner mu Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natu
aumatic event, the Medical 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. Do NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Martin's 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Garnett L. Shoemate George T. Bruce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1515 St. Christoper Court Edgewood MD21040 Nicole Chapman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 10/31/12 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Lervice License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ MATASTIC disease or condition resulting in death) CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death signed by the al 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s performed?

1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Other: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation after death

Director: A
d in by the f Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined n 24 hours the Funeral Dire Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one)

State Registrar

M DHMH 17 Rev 06-2011

29b. Signature and title of certifier

KIRMANJ 31. Date filed (Month, Day, Year)

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMED

9000

SQUARE DR

FRANKLIN

29d. Date signed (Month, Day, Year)

mo

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Bubb 2012 Nancy Lee 3:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cleveland Road Anne Arundel Linthicum Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 212-44-2469 **Director** MD 07/07/1945 67 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Linthicum 1 ☐ Yes 2 🔀 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 620 21090 Cleveland Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes XX No
If Yes, Give Black, White, etc. þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXXVo Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Claims Representative Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Dieterich Madeline Norgran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ellis Bubb / Husband 620 Cleveland Road Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial XX Cremation 3 ☐ Removal from State 5√☐ Other (Specify) 4 Donation 11/1/2012 Atlantic Crematory Glen Burnie, MD 21061 21. Signatur eral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List o Interval Between Immediate Cause (Final Onset and Death Physician/ BREDGT CENEZA disease or condition resulting in death) METASTATIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 after death.

Director: After this certificate has autopsy perform 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ပ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MO 18320 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John & Risan 10753 tall State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 29, **Physician** Priscilla 0830 Evelyn Briney 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2 🕇 F Months Hours Days Maryland 0370271917 220-01-4368 95 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Nuclical Experient must be notified at 1 ☐ Yes 2 No Director Churchville Harford Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21028 USA 417 Calvary Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2.XXXIo Specify white þ Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Country Club **Hostess** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Priscilla Harry Eldon Sheridan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 2704 Clever Lane, Churchville, Maryland 21001 (daughter) Lois Thompson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition BelAir Memorial Gardens 11/2/2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BelAir, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Lie Aberdeen, Maryland 21001 Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or darping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Hlpknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ ↑ Tyes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy 20 No 1 ☐ Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 254No Inpatient 2 ER/Outpatient 3 DOA Certification: To of filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral D the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and timof certifler 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ause of deal ntem 23a) (Type, Prin

Registrar

State

one

31. Date filed (Month, Day,

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	A C		Usual Residence o	of Decedent	^^						Jan. 7,	1949	<u>' </u>	MD	
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	th the		10e. Street and Num					10f. Zip Co	de			10g. C	itizen of What C	ountry?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Funeral	7858 Leyman	• Rd.	12. Was Decedent	Francia III 6	2 40 4		21060	0-1-1-0 (0-	-14 - 14 - 14 - 14 - 14		USA		
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ဗ္ဗ	s afte ral", o	å g	3 Widowed 4		If Yes, Give Year or Dates.	NIVO	1	☐ Yes 2X	No Spec	cify:			Specify:	ite	
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Зlа	ould be fil nd Mental marked matic ev	-	Samuel Lamb					_	Ec	dna 1. :	Spiker				
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Baltimore, Maryland 21215-0036	ge 1 ar of F				☐ Removal from State	20b. F	Place of Disposemetery, crem	sition (Name on natory or othe	of place)		Date		_ocation - City o	r Town, State	
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Ba	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other	13	21. Signature of Fun	Fink	ee	ر ۳۵11 <i>ه</i>	22.	Name and A	ddress of Fa I neral H	lome, P.	.A.		1.051		
7		\vdash	23a. Part Enter th	ne disease, or on	nplications that cause	MO1148 d the death		r the mode of	dving, such	as cardiac o	en Burnie or respiratory ar	rest.	21061	Approximate	
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2	ding th. After	cate	1 Natural 2 Accident	5 Pending	(Month, Da	y, Year)	injury		work?		28d. Describe h	now inju	ry occurred		
<u> </u>	Atten r dea ctor;	ertificate:	3 Suicide 4 Homicide	Investigatio	De 280 Place of Ini	urv - At ho	me, farm, stre				28f Location 6	Street ar	nd Number or Ri	ıral Route Number.	
DIVISION OF	al or safte	O	4 La Homicide	determined	building, et			,,,			City or Tov			rai rioute ruiribei,	
_	ospita hours inera ly fille	lical	29a. Certifier 1	Certifying Phy	rsician: To the best of	my knowle	edge, death o	ccurred at the	time, date a	ind place, ar	nd due to the ca	ause(s) a	and manner as s	tated.	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2 l only one) 3 l	Medical Exam	niner: On the basis of e rse Practitioner: To th	examination	and/or investi-	gation, in my	pinion, death	occurred at	the time, date a	and place	e, and due to the	cause(s) and manne	er stated.
	Vith Voith Con I		29b. Signature and ti		000	4		29c. Lic	ense numbe	r		29d. Da	ate signed (Mont	h, Day, Year)	
			Lugens	Thomas	knon	1710		0	0036	247		10	0/31/2	0/2	
			30. Name and addres	as of person who	completed cause of d	leath (Item	23a) (Type, Pr	rint)	11 //	1	410	-	- /	er 90 210	
			Eugene	home				Intche	115 (ha	nce Kel	11/80	to	agendat	er 170 210	37
	Stat Registra	-	31. Date filed (Month,		32. Jegistra	ar's Signat	ure da	ake							
			- 17	4 5 5 T 3 F 45 F	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTO! DWW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Zande Hookins scountinoce If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) 8 Date of Birth Funeral Days Hours AUG 21 2 1941 Director 334.34.6837 71 1 XX 2 F Usual Residence of Deci item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director FREDERICK FREDERICK 1 Yes 2XX No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6238 WHITE OAK DR. 21701 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **GENERAL SECRETARY-TREASURER** TRANSPORT.& COMM. UNION 250 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H HARBIN RILEY CHAPMAN **OLETHA MAE MURRAY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is r KATHRYN ELLEN LOUELL 6238 WHITE OAK DR. FREDERICK, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ŏ 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State OAK WOOD CEMETERY OCT. 29,2012 4 Donation 5 Other (Specify) MACOMB, IL 21. Signar re of Funeral Service Licen 22 Name and Address of Facility P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. CREGORY PUNK M01148 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ nyelodys disease or condition resulting in death) Dla. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Directo for es a nonsequence off Examin Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year ☐ Pregnant at time of death 9 Unknown 9 | Unknown ate has been signed by 1 page 2 should be detacl Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate 1 Yes 2 No director, 25. Was case referred to manical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 2 🗓 n 24 hours after death. ne Funeral Director: After this or pletely filled in by the funeral dir 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) title of certif 29b. Signature and 29c. License number WD 30. Name and addre ss of person who completed cause of death (Item 23a) (Type, Print) 800 Andrew MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signature NOV 0 Registrar

12-08017 Gregory Cole Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 34758

			1- For State Registrar		ertificate of D	eath	F	Reg. No.	
Phys edical Exa			1. Decedent's Name (First, Middle, La	cole Cole			2. Date of Dea Month October 2	Day Year	3. Time of Death 0253 hrs
			4a. Facility Name (if not institution, gi Maryland General Hospit	,		City, Town, or Location of altimore	f Death	4c. County of Dea	I.A
Fune Direct			5. Social Security Number 6. S		F-20 1	Under 1 Year If Under Months Days Hours	24Hrs. 8, Date of B	Fore	
	٦		Usual Residence of Decedent	¥M 2 F	50 Yrs.		Lluly	12, 1962	
and show any	nce.	5	10a. State 10b. County	10c. c	Balti	nore			10d. Inside City Limits 1 Ves 2 No
eath with the Maryland items 23a or 28a-f show any	ified at 0	Funeral Director	10e. Street and Number	ado Ave	10	f. Zip Code		10g. Citizen of What Co	untry?
ath with t	st be not	neral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces?	If Yes,	ecedent of Hispanic Drigi specify Cuban, Mexican,	in? (Specify Yes or N	14. Race - Ame White, etc.	erican Indian, Black,
s after de iral", or		۵		1 Yes 2 No	1 Yes	No specify:	ind of court days	Specify:	Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nastural", or items 23a or 28a-f she	traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	during most o	Isual Dccupation (Give k of working life. DO NDT u		Self-	Euployed
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	nt, the M	Be Cor	17. Father's Name (First, Middle, Las	le.			Name (First, Middle,	Maiden Surname)	- 1
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygione Important: If item 27 is marked other II.	ımatic eve	٩	19a. Informant's Name/Relationship (Audrey L	Type, Print) Brooks	19b. Mailing Ad	Eldorad	per or Rural Route Nu	Balh mo	te, Zip Code)
IOFE, I ges 1 and it of Healt	other trai	Ī	20a. Method of Disposition 1 Surial 2 Cremation 3	Removal from State	b. Place of Disposition crematory or other p		Date Date	20c. Location - City o	or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If iter	injury or	ł	4 Donation 5 Other Specification of Funeral Service Lies		22. Name	and Address of Facility	10/27/201	1 Funer	al Home
Physicia	an	\dashv	23a. Part I. Enter the disease, or comfailure. List only one cause on e		ath. Do not enter the m	ode of dying, such as ca	rdiac or respiratory an	est, shock, or heart	Approximate Interval Between Onset and
/Medic Examin			Immediate Cause (Final disease or condition resulting in death)	Intracerebellar Hemo					Death
		_	Sequentially list conditions, if any, leading to immediate	Hypertensive Heart D					
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence					
760, Icate be executed s physician and	transit		events resulting in death) Last						
760, Icate be executed physician and	burial	Medical	UNPENDED	AMENDED				Loos Baratan	
6876 ertificat ding phy		- 14	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	2 Fetal d	eath 3 Ectopic	pregnancy	23d. Date of delive Month	ry Day Year
Box 68 e death certifi	ed for us	Physician	1 Yes 2 No 9 Unknow	Pregnant at time of 9 Unknown	death 5 Other	(Specify)			
P.O. Be es that the designed by the a	deta	۵	Part II. Other significant conditions	contributing to death but no	ot resulting in the under	lying cause given in Part		obacco use contribute to s 2 No 3 Pro	
cords, P.C law requires that has been signed b	CI	Completed					24a, Was autop perfo		outopsy findings available completion of cause of
tal Rection: The			25. Was case referred to medical			26.Place of Death (0	1 ✓ Yes		es 2 No
Vita hysician this cer		ň		Hospital: 1 Inpatient 2	✓ ER/Outpatient 3			Residence 6 Oth	er:
Division of Vital Records, P. In a Attending Physician: The law requires the safter death. al Director: After this certificate has been signe	fune	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b, Time of Injury	28c. Injury at Work?		how injury occurred	
Division Attains after de ral Directe	filled in by the	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	be 28e. Place of Injury - At	t home, farm, street, fa	ctory, office building, etc.	28f. Location (or Town, \$		ural Route Number, City
the Hos hin 24 h the Fu		ह्र	29a. Certifier 1 Certifying Physic	ian: To the best of my knowler:On the basis of examination	-	The second secon			
5 vi 5	COL	ĕ-	29b, Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (M	onth, Day, Year)
			Potr Cin	Kollen	~~	O.C.M.E.		October 24, 201	2
N			30. Name and address of person who Patricia Aronica-Pollak M	D. Assistant Medica	I Examiner 900) W. Baltimore Stre	eet, Baltimore, M	D 21223	
Rec	Sta	••	31. Date 1 (1) (1) (1), Pa (2) (4)	32. Registrary Signa	market		-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mai	ryland		artmen tificate			and M	lental Hy	•	201	2	34	750
	Physicia	n/	1. Decedent's Name (First, Middle, Las	,			incare	OIL	Caur		2. Date of De	Day	v Ye	ar	3. Time o	of Death
0	Medic Examir	al	Irene Gansl Cooperman 4a. Facility Name (if not institution, give 7605 Charleston Orive	street and number)			4b. City, ³		Location of	f Death	10	21 4c.	20° County of C	12 eath	1:30	РМ
	Funeral Director		5. Social Security Number 6. S		ln yrs. las	st birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 4-8-191	th	T g.		ace (State y) New	or Foreign York
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County MO Montgomer 10e. Street and Number 7605 Charleston Orive	у	8eth	Town or Loc	10f. Zip 2081	7		: 0.40		Unit	izen of What ted Sta	: Countr	ry?	City Limits s 2 ☐ No
Maryland 21215-0036	in 72 hours after dea e. nan "natural", or ite Medical Examiner	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.		0	16a. Deced (Give k	ent's Usua ind of work NOT use	Occupa done d retired)	Specify: ation uring most	of workir		16b. Ki	14. Race - A Black, W Specify: ind of Busine	hite, et	tc. Hite ustry	
/land 21	d be filed with Mental Hygien arked other th	To Be Co	17. Father's Name (First, Middle, Last) Marcus Gansl	5+		Direct	or of	Voca		r's Name	seling (First, Middle, Unknown)		Surname)	Admir	nistra:	ition
	nd 2 should ealth and N m 27 is ma ier trauma		19a. Informant's Name/Relationship (7) Marc Cooperman - Son	/pe, Print)			~				Route Numbe	er, City or	Town, State,	Zip Co	ide)	
Baltimore,	Page 1 ar ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 C 4 Donation 5 D Other (Speci		ce	ace of Dispos metery, crem David	atory or ot	her place		_	ate -2012		ocation - City B Churcl			a
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Usens	ee Edward Sag	el				s of Facility le Pike		Oanzans ckville,			852		
	h, i i n Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer ' Oue to (or as a c	s Ois	nce of):	r the mode	of dying	g, such as c	cardiac o	r respiratory ar	rest,			Approxima Interval Be Onset and	tween
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Aspiration Due to (or as a c	ionseque	nce oi).										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal	death 3 🗌	Ectopic p		<i>y</i>		1000 1 10 10 10		23d. Date of Month		-	Year
rds, P.O.	requires that to been signed board beard beard	eted by P	Part II. Other significant conditions of	ontributing to death but	not resul	ting in the ur	nderlying c	ause giv	en in Part I.		1 🗆	Yes 2	Se contribute	Proba	ably 4 🗆	Unknown
al Records,	an: The law itificate has both		25. Was case referred to medical					26. Pla	ice of Death	n (Check	1 🗆 Yes		prior death	to com	sy findings apletion of a	cause of
n of Vital	ding Physicie th. After this cer funeral direct	욘	examiner? 1 Yes 2 No 27. Manner of Oeath 1 No Natural 5 Pending 2 Accident Investigation	Hospital: 1 Inpatient 28a. Date of injury (Month, Day, Y	2	R/Outpatient 8b. Time of injury		Othe	r: 4 □ Nur at	rsing Hor	ne 5 🔀 Resident			pecify)		
Division	ital or Atten urs after dea ral Director. lled in by the	al Certificate:	3 Suicide 6 Could not b	28e. Place of Injury building, etc. (Specify)		et, factory,	office		2	28f. Location (S City or Tov	vn, State)				ber,
	To the Hosp within 24 hor To the Fune completed fil	Medical	(Check 2 Medical Exami	sician: To the best of my ner: On the basis of exar se Practioner: To the be	mination a	and/or investi	gation, in meath occum	ny opinio	n, death occ time, date a number	curred at	the time, date a	and place, le cause(s 29d. Dat	and due to t	he caus as stat onth, Da	e(s) and material	anner stated.
5			30. Name and address of person who of Ava Kaufman, MO - 82		,	, , , , ,	,			816	<u> </u>					
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signatu	bark	7									

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 FRANCES 29 10 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA BALTIMORE TIMONIUM 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country) 137-24-3584 Director 1 □ M 2 🔀 F 07-26-1921 Usual Residence of Decedent 28a-f show Town or Location 10d Inside City Limits the Medical Examiner must be notified at Director MD BACTIMORE 1 Yes 2 No ARKVILLE ö 10g. Citizen of What Country? Funeral with 23a 4 CLEARLAKE COURT 21234 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: and Mental Hygiene. is marked other than "natural", Specify: 3 ₩ Widowed 4 □ Divorced BLACK Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) UNK Laborer FACTORY Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, for the stannatic event Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosia Brockenbrough LAWERENCE MUSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Clearlake Court · Parkville, MO · 21234 Louisiana GRIFFIN/DAUghter Baltimore, CTOBER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MOUNT ROYAL, NJ GATES OF HEAVEN 11-6-12 4 Donation 5 Other (Specify) 21. Signatur of Funeral Pervise Licensee 22. Name and Address of Facility VAUGHN GREENE FUNDRALSCUS 4905 York Road · Baltimore, Md. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between st in Death Immediate Cause (Final DEMENT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) IF FEMALE: nse 23d Date of delivery 23b. Was decedent pregnant for 1 in the past 12 months?
1 Yes 2 No
9 Unknown 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TES 2 No cate has been sig page 2 should b 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 🗆 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? iniury 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific Hera CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS 2300 DULANEY VALLEY ROAD TIMONIUM.

Registrar

State

31. Date filed (Month, Day, Year,

NOV U 1 2012

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year \mathbf{P}^{M} Milton Lee Cox, Jr 2012 Medical <u>October</u> 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u> Glen Burnie Health & Rehab Center</u> <u>Glen Burnie</u> <u>Arundel</u> Anne 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 577-44-6694 **Director** 1 🗶 M 2 🗆 F 77 Feb. 4, 1935 Washington, DC or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😿 No Anne Arundel Maryland Jessup 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r 10a, Citizen of What Country? Funeral 7810 Clark Road E-8 20794 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 X Married X Yes Yes, Giv within 72 hours after 2 No Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates.1953-1973 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygier 7 is marked other t Human Resources Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ : If item 27 is marke or other traumatic Milton Lee Cox Silvia Boucher of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Clark Road E-8 Jessup, Maryland 20794 Sharon Cox / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date ğ 1 X Burial 2 Cremation 3 Removal from State November 1, 2012 Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Veterans Cemetery Crownsville, Maryland MD Sign uneral Se 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A 411 Annapolis Road Odenton, Maryland 21113 Part 1 Enter the disease, or complications that eacsed shock or heart failure. List only one cause on each line. mplications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Lung Cancer with Brain Metastasis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, iner if any, leading to immediate Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed and the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 ass IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed? Yes 2 X No autopsy death? after death.

Director, After this certificate I 1 ☐ Yes 2 ☐ No Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State

Registrar

29b. Signature and title of gertifier

Reshma Modi, MD 6934

noou

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrari Signature

29c. License number

H0059653

Aviation Blvd. Ste B Glen Burnie, Maryland 21061

29d, Date signed (Month, Dav. Year)

October 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ riene Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17 Sumac Road Apt A Glen Burnie Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Days (Month, Day, Year) Hours 214 58 1450 60 Director 1 □ M 2 X F Dec 1, 1951 Washington DC 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 17 Sumac Road Apt A 21060 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify "natural", Whi.te Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Customer Relations Lowes Home Inprovement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bernard W. Hurlock Mary Frances Windsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s t of Health a If item 27 i 12111 Northwood Drive, Upper Marlboro, MD 20772 Mary Frances Hurlock (mother) 20a. Method of Disposition

14 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot cemetery, crematory or other place, Page 1 Resurrection Cemetery Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 31, 2012 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lee Funeral Home, Inc 6633 Old Alexandria 14101549 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or convilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death CARDIOM Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death P.O. signed by to be detact Part II. **Other significant conditions** contributing to death but not resulting in the underl<u>y</u>ing cause given in Part 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to ompletely filled in by the funer. (Month, Day, Year) Natural Accider 5 Pending 1 Tyes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

39. Name and address of person who comple

PORNIMA
31. Date filed (Month, Day, Year

NOV 0 1 2012

of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day РМ 2012 Geneva Charlene Cotter Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2 Woodside Conowingo Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/17/1953 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Virginia Days Hours Director 1 - M 2 F 218-62-4914 58 Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Yes 2 No MD Cecil Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Woodside 21918 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of i. Page 1 and 2 should be fill tment of Health and Mental tant: If Item 27 is marked o ည Charles Poore Bernice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Cotter / Husband 2 Woodside, Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Dor<u>ota Marshall</u> Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ perte Medical resulting in death) Due to r as a consequence of: Examiner Sequentially list conditions, Examine if any leading to immedia cause. Enter Underlying Cause (Disease or injury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
etely filled in by the funeral director, page 2 should be detached for use as the burial-transif that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy _2 DN 1 Yes 2 🗌 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XX မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of-certifier T0055026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 Raylandsv. 11e Rd. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 4:55 P 2012 Physician/ Roberta L. Coyle Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Rossville Manor Care - Rossville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Aug. 14 Months Hours Min New 57 Yrs. 1 🗆 M 2 🔀 F 1955 218-68-7083 York Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County notified at Director Baltimore Essex MD 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō or than "natural", or items 23a on the Medical Examiner must be by Funeral USA 501 Chaocot Square 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 Firment of Health and Mental Hygiene. Eant: If item 27 is marked other than "n jury or other traumatic event, the Medi College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker 2yrs 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Doris Boutell Carl Mowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 501 Chaocot Square Baltimore MD 21221 Alycha Travers /daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot Bayview Crematory ☐ Burial 2X Cremation 3 ☐ Removal from State 10/31/12 Baltimore MD 5 Other (Specify) 4 Donation 300 Mace Ave. Balto. MD 22. Name and Address of Facility 21. Signature of ineral Service Licenses Connelly Funeral Home of Essex 21221 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or comb 23a. Part 1. Enter the disease, e cause on each line. shock, or heart failure. List only Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day in the past 12 mont Pregnant at time of death 9 Unknown g Unknown this certificate has been signed by the ral director, page 2 should be detached P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 - No 2 2 N 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital completed filled in by the funeral director, Be Other: Nursing Home 5 Residence 6 Other (Specify) 2010 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 1 Yes 28b. Time of 28c. Injury at work? 1 \(\text{Yes} 2 \(\text{No} \) 28d. Describe how injury occurred 27, Manner of Death 28a. Date of injury Certificate: within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural Natural 5 Pending M Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print) 88 0. Name and address

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Merita DSOOA Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Country View Assisted Living Darlington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 164-05-3319 1 🗆 M 2 🔀 F 96 10/20/1916 New Jersey or then "neturel", or iteme 23e or 28e-f ehow the Medical Exproper must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter deeth with the Maryland 10a. State Director 1 🗌 Yes 2 🏻 No Darlington Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21034 U.S.A. 4104 Conowingo Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Solderer Metals 12 should be filed wit ofth end Mental Hygie 27 Is marked other r treumetic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) ၉ George Levi Zane t. Pege 1 end 2 should b rtment of Heelth end Mer rtent: If Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4104 Conowingo Road, Darlington, MD 21034 Ray Capman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pege 1
Depertment of
Importent: if it
eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/01/2012 Hanover, Maryland 4 Donation 5 Other (Specify) Anatomy Gifts Registry Anatomy Gifts Registry 21. Signature of Funeral Service Lices 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherisa Physician levi Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires thet the death certificete be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physician end completely filled in by the funerel director, page 2 should be deteched for use es the burlel-trensi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) g 🗌 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🔲 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year) NOV 0 1 2012 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1108 Broadmoor Ct. Harford BelAir 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director 002-32-9525 1 X M 2 □ F 66 July 30, 1945 New Hampshire 28a-f shov 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be nutflied at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Kyes 2 No Maryland Harford BelAir 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1108 Broadmoor Court 21014 USA Was Decedent Ever in U.S. Armed Forces? 1 № Yes 2 □ No 1967 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: and Mental Hygiene. Is marked other than "natural", If Yes, Give 1971 3 🗌 Widowed 4 🗆 Divorced white Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) repair technician music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or cate. Edward Church Isabele Forbes Carl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Church 1108 Broadmoor Court, BelAir, MD 21014 (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ferris & Company 11/1/2012 West Chester, PA 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. Signature of Funeral Service Licenses Maryland 21001 Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ anana disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executivitin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-rise. resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year After this certificate has been signed by the function of the function, page 2 should be detached a | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who compl

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 Florence Gedge Dennis 06:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPIZAL N/A OF BAUTIMORS BALTIMORY Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 293-66-1549 **95** Days Director 1 □ M 2 🕇 F July 04,1917 Cleveland, Ohio Usual Residence of Decedent item 27 is marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Modical Examiner is ust to inclined at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Baltimore County Towson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road Apt. 1011 21286 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 → Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 2121 College (1-4 or 5+) **04** Elementary/Secondary (0-12) Home Maker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Importent: If item 27 Is marked ot eny Injury or other traumatic ever Once. Mental Herbert Burton Gedge Lucile Bower pe Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia D. Palm (Daughter 229 Gaywood Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Evens Funeral. Chapel and Cremation Services, Inc. 20a. Method of Disposition 20c. Location - City or Town, State (Harford County) Wednesday 1 🗆 Burial 2XI Cremation 3 🗖 Removal from State Oct. 31, 2012 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Segree Licensee Jeffrey L.Gair, Sr. (15)? 2. Name and Address of Facility.

21. Signature of Funeral Segree Licensee Jeffrey L.Gair, Sr. (15)? 2. Name and Address of Facility.

21. Signature of Funeral and Cremation Center, P.A.

21. Signature of Funeral Segree Licensee Jeffrey L.Gair, Sr. (15)? 2. Name and Address of Facility.

21. Signature of Funeral Segree Licensee Jeffrey L.Gair, Sr. (15)? 2. Name and Address of Facility. 2325 York Road Timonium, Maryland 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULAR Onset and Death Pnysician/ ACCIDENT Medical resulting in death) Due to (or as a consequence of): Examiner DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclen and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 N No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death n signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERIPHIRAL 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔀 No After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) KOSPICS Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hir hig RES 000 OCTOBER 28,2012 MBBS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 SINAT HOSP. OF BALTIMORE, 2401 W BSWEDERLAVE BALTIMORE, MSZEIS 31. Date filed (MonW Day, Y ar) 2012 32. Registrar's Signature State Registrar

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FLORE NCS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OYLE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 2228 Kentucky Ave. Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye. Birthplace (State or Foreign Country) **Funeral** Days Hours 216-20-8788 86 1 X M 2 D F **Director** Nov. 03, 1925 Beaver County, PA Usual Residence of Decede shov 10a, State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo 1 🛚 Yes 2 🗆 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2228 Kentucky Ave. 21213 United States Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Navy Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates. W.W.II 3 XWidowed 4 Divorced Specify: Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4 or 5+) **N/A** Elementary/Secondary (0-12) 12 Electrician Bethlehem Steel Be other traumatic event, permit. Page 1 and 2 should be filed.
Department of Health and Mental Hw.
Important: If item 27 is mar.
any injury or other: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Doyle, Sr. Dorothy King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2228 Kentucky Ave. 21213 Mr. Timothy J. Doyle, Sr. (Son) Baltimore, Maryland 20b. Place of Disposition (Name of Date 20c. Location - City or Jown, State (Harford County) 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Exams Furnation or other place Wednesday Oct. 31, 2012 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Cremetion Services, Inc. Perceil Alternatives Funeral and Cremation Center, P.A. Signatur Lic.#M00677 2325 York Road Timonium, Maryland furt 1. Egief the disease or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burlal-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy After this certificate has been signed by the atter in the past 12 months? Day 1 Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 L 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Attending 5 Pending Natural injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, Statel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year, ed cause of death (Item 23a) (Type, Print) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar		Certificate of l	Death		Reg. No.	12 34/65	j
П	Physicia	n/	1. Decedent's Name (First, Middle, Las	<i>t</i>)			2. Date of Dea		3. Time of Death	
	Medic	al	Mary Ell	en Down			10-2	7-201	-	
	Examin	er	4a. Facility Name (il not institution, give 34.36 Woods	street and number) FOCK Avenue	_ /	r Location of Death		4c. County of	of Death	
- A	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last b	oirthday) If Under 1 Year		8. Date of Birt	h	9. Birthplace (State or Foreign	7
	Director		214-22-5921 1	□M2 1 89	Yrs. Months Days	Hours Min.	Month, Da	723	Country) VA	
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	or 28 or noti	盲	10e. Street and Number	1/54/1	10f. Zip Code			10g. Citizen of W	/hat Country?	_
	with 1 s 23a ust b	Funeral Director	3436 Woods	tock Avenue		1/2/3		U-	SA	
	item:		11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc.	
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1 🗆 Yes 2 🖼 No	•		Specify:	21 /	
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Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		21. Signature of Fundral Service Licens	* 1.	22. Name and Addre	ess of Facility	ichn C.	Greene, F	Funeral Service	S
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89	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date	e of delivery	
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	Registr		NOV U 1 20		parked					

Registrar

Physician Medical Examiner Description have first Medical Last) Description have first Medical Last Medic				Please ¹	Type or Print in Black In	delible Ink. Ensure	All Copies Ar	e Legible.	0
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Second Residence of Decedents 10c. City, Town or Location 10d. Inside City Literary 10d. Inside City Liter				5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		9. Birthplace (State or Fore Country)	ign
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Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	+3	Physician/	2 2	shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.			Interval Between Onset and Death	Ų
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PROPOSE A CONSEQUENCE OF STATE		cuted ind transit	xami	Cause (Disease or injury that initiated events)				
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23b. Was decedent pregnant in the past 12 months? 1 Ves	876	tificate ng phy	Medi	IF FEMALE:	1.				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Vunk 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Vunk 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 Yes 2 No 2 Yes 2 Ye	9 x o	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal death 3 L				
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25. Was case referred to medical examiner? 1	Rec	The lev ate has page 2	Som			-	performed	death?	of
2 St. 2 St. Manger of Death 2 St. Date of injury 2 St. Time of Windship Age of the W	ita	siclan: certific irector,		examiner?	ospital:	LOthor			-
	of <	ig Physical this neral di		27. Manner of Death	28a. Date of injury 28b. Time of	3 ☐ DOA 4 ☐ Nursing I			\dashv
To be	ion	ttendin death. tor: Aff	Certificate:			M 1 Yes 2 No			
28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	Sivis	al or Al		4 Homicide determined		et, factory, office			
The state of the s	_	Hospit 4 hour Funera tely fille	dica	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	cian: To the best of my knowledge, death or er: On the basis of examination and/or investig	ccurred at the time, date and place, gation, in my opinion, death occurred	and due to the cause(s at the time, date and pla) and manner as stated. ice, and due to the cause(s) and manner s	stated.
only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		Fo the Vithin 2 Fo the Comple	ğ		Practitioner: To the best of my knowledge, or				
RES-000 October 26,20		O 0.1		M	0	RES-000	00	Hober 26,201	ح
30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Raymond RYUMG MD 1800 Orleans St. Balhomore, MD 21287		7/1		/ / / //			altim-ra	40 2000	
State Registrar State Registrar				31. Date filed (Month, Day, Year)		1	-1111111111	, , - 1.2 2 1.28	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day + Physician/ Barbara Ann Dix Month Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death baltimore Huspital N/A Sirai Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours 214-92-9675 **Director** 1 □ M 2 XX 48 MD January 13,1964 Usual Residence of Deceder ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1XX Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4221 Hickory Avenue Apt. B 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 XX Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or If Yes, Give Year or Dates 1 Yes 2 TXNo Specify: 3 UVidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 212 Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Dix Barbara Jean Hubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal DeVor (Daughter) 4403 Falls Bridge Drive Apt. F Balto, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/3/12 Glen Burnie. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗆 No 잍 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending eral Director: A Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type_Print) 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kavier	Nico	Dutchover	

		2	0	-	2	3	4	7	7	9
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		1- For State Registrar Certificate C	of Death	Reg. No	U	. 5417
Physici	an/	Decedent's Name (First, Middle, Last)		Date of Death Month Day	Year	3. Time of Death
Medical Exami	ner	Xzavier Nico Dutchover 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	October 23, 20	012 c. County of Death	0312 hrs
		Baltimore Washington Medical Center	Glen Burnie		Anne Arundel	
Funeral		Social Security Number 6. Sex 7. Age (In yrs, last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth(MM		place (State or
Director		834-75-1633 1XM 2F 0 Y	Months Days Hours Mir	08/18/20	12 Foreign	ntry) Maryland
		Usual Residence of Decedent				
v any		10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits
land f sho	ō	MD Anne Arundel Glen Bu				1 Yes 2 X No
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Count	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once		1215 Whitman Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21061 /as Decedent of Hispanic Origin? (S	resoits Von er No	U.S.A	
ath w	Funeral	1 V Never Married 2 Married Armed Forces? If	Yes, specify Cuban, Mexican, Puerto		White, etc.	ari iridiari, biack,
fter de		3 Widowed 4 Divorced If yes 2 X No If Yes 2	Yes 2 No specify: Mex	cican	Specify: Wh	nite
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of most of working life. DO NOT use re		Kind of Business/In	dustry
7	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		54,	N/A	
15-0036 filed within 72 I Hygiene, ed other than "	E	0 17. Father's Name (First, Middle, Last)	N/A	e (First, Middle, Maide	-	
	BeC	Richard Alan Dutchover, Jr		Ann	Grail	
2121 ould be fi I Mental	5		ng Address (Street and Number or	Rural Route Number, 0	City or Town, State,	Zip Code)
MD and 2 sho alth and m 27 is aumati		113: Bara 11111 Graff / Hother	15 Whitman Drive			
Q 4 5 5 7		20a. Method of Disposition 20b. Place of Disposition Removal from State 20b. Place of Disposition or of the place of Disposition or of Di	· · ·	i	. Location - City or T	
imC Page ment tant:	Į	4 Donation 3 Other Specify.			Glen Burn	
Baltimore, permit. Pages 1 ar Department of Her Important: If ite			Name and Address of Facility 1 2			
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter				Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden Unexplained D	eath In Infancy	(SIIDT)		Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	eden in initialey	(BODI)		
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	nine	cause. Enter Underlying Cause				
lisit ed (Examine	events resulting in death) Last Due to (or as a consequence of):				
760, frate be executed physician and the burial - transit	g	d. X UNPENDED X AMENDED 1 as noted, 23a	.,27,28a-f,per me	,g935 1-7-	13 sm	
60, ate be hysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			3d. Date of delivery	
687 ertifica ding p		23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregn	ancy	Month Da	ay Year
Box 687 c death certific the attending r ed for use as the	Physician/	4 Pregnant at time of death 5 0	Other (Specify)			
P.O. Box 687 that the death certificated by the attending detached for use as the detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
, P.O.	d b			1 Yes 2	No 3 Proba	ably 4 🗸 Unknown
ords, F w requires s been sign should be	ete			24a. Was an autopsy		opsy findings available ompletion of cause of
Reco The law icate has	Completed		<u> </u>	performed?		2 No
Division of Vital Records, tal or Attending Physician: The law requinrs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical	26 Place of Death (Check	only one)		
Vit	10 E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien			lence 6 Other:	
ion of tending Pheath.		27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day, Year) 28b. Time of (Month, D	1 Ves 2 No	28d. Describe how in unknown	njury occurred	
Atten Atten r deat ector by the	icati	2 Accident Investigation Accident Investigation 28e. Place of Injury - At home, farm, str	/ am	28f. Location (Street	and Number or Rura	al Route Number, City
Div	Certification:	3 Suicide 6 Could not be determined (Specify) found at hor		or Town, State). Glen Burni		al Route Number, City
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a, Certifier 1 Certifying Physician; To the best of my knowledge, death occ	urred at the time, date and place, an	d due to the cause(s) a	and manner as state	d.
To the within To the comple	Medical	one) 2 Medical Examiner:On the basis of examination and/or investig and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Mont	
		Totalen- Tolleen	O.C.M.E.		tober 24, 2012	
(b)		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	900 W. Baltimore Street,	Baltimore, MD 21	223	
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regis	trar	NUV 0 1 2012 General B. Sarles				
		B 16 / 10/2E				

homas Lane Edwa	rds State of Marylan	d / Department of				
	1- For State Registrar	Certificate of	Death		g. No. 20	2 3477
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) Thomas Lane Edwards			2. Date of Death Month October 19		3. Time of Death 0148 hrs
	4a. Facility Name (if not institution, give street and number 237 Somers Cove	ber) 4	 b. City, Town, or Location of Crisfield 	of Death	4c. County of De Somerset	ath
Funeral		Age (In yrs. last birthday)		r 24Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9.	
Director	226-43-8963 1XXM 2 F	30 Yrs.	Months Days Hours	Min. April 26		reign Country) VA
b	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	200			10d. Inside City Limits
and show any nce. Or						1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	VA Roanoke 10e. Street and Number	Roanoke	10f. Zip Code	10	g. Citizen of What C	
3a or 3	3133 Maplelawn Ave.		24012		USA	
or items 23:	11. Marital Status 12. Was Deced 1 XX Never Married 2 Married Armed Force	es? If Ye	Decedent of Hispanic Origes, specify Cuban, Mexican,		14. Race - An White, etc	nerican Indian, Black,
frer de l'', or i	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	2 XX No	Yes 2 XX No specify:		Specify:	Nhite
hours after death with the Maryland Examiner must be notified at once ted by Funeral Director	15. Decedent's Education (Specify only highest grade	during mo	s Usual Occupation (Give lest of working life, DO NOT		16b. Kind of Busine	ss/Industry
5-0036 ed within 72 hour lygiene. other than "uatu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4		mp1 oyed		Unemplo	ved
21215-0036 uid be filed within 72 hours at Mental Hygiene. marked other than "marked cother than balanca cevent, the Medical Examine To Be Completed by	17. Father's Name (First, Middle, Last)	Office		s Name (First, Middle, M		, cu
121 d be fill fental I arked event,	Thomas Woolridge 19a. Informant's Name/Relationship (Type, Print)	40h Mailine	Address (Street and Num	Ruth Pierce	has City as Taylor Ct	ata Tia Oada)
e, MD 21215-0036 1 and 2 should be filed within 72 Health and Mental Hygiene. Tiem 27 is marked other than " r traumatic event, the Medical. To Be Complet	Shawn Martin_Edwards		eerfield Ct., Ro		•	ate, Zip Code)
re, N. I and I health	20a. Method of Disposition 1 Burial 2 XX Cremation 3XX Removal from	20b. Place of Disposit	tion (Name of cemetery,	Date	20c. Location - City	or Town, State
imore Pages i nent of H ant: If it or other	4 Donation 5 Other Specify:	Bayview Crem		Oct 22, 2012	Baltimore	, MD
% # ₽ # ₽	21. Signature of Funeral Service Licensee	Fi	ame and Address of Facility nk Funeral Home	, P.A.		
\ Physician	K. Gregory Fink M01148 23a. Part Enter the disease of complications that cause	sed the death. Do not enter the	6 Crain Hwy S., e mode of dying, such as ca	Glen Burnie, ardiac or respiratory arre	MD 21061 st, shock, or heart	Approximate Interval
Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Guns	shot Wounds				Between Onset and Death
± Xammer	or condition resulting in death) Due to (or as a co	onsequence of):				
Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a co	onsequence of):				
ted nisit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co	onsequence of):				
	d					
o .a .a .	UNPENDED AMENDED				Look Day (dall)	
3876 rtificate ing phy as the	23b. Was decedent pregnant in the past 12 months?	2	al death 3 Ectopic	pregnancy	23d. Date of delive Month	ery Day Year
Box 68760, death certificate be the attending physici of for use as the burinysician/Med	1 Yes 2 No 9 Unknown 9 Unknown		er (Specify)			
Records, P.O. Box 68760, The law requires that the death certificate be lost totat has been signed by the attending physic page 2 should be detached for use as the burn completed by Physician/Med	Part II. Other significant conditions contributing to d		nderlying cause given in Pa	rt I. 23e, Did tol	bacco use contribute	to the cause of death?
s, P.O.				1000000	2 ✔ No 3 F	
cords, law requir has been s 2 should				24a. Was a autops perfori	sy prior	autopsy findings available to completion of cause of
tal Records, isan: The taw requires conflicte has been signed; page 2 should be Completed				1 ✓ Yes 2		
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been signified in by the funeral director, page 2 should bedical Certification: To Be Completed	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inp	atient 2 ER/Outpatient	26.Place of Death (Residence 6 🗸 Ot	her: Scene
of \ing Phy ing Phy After the uneral on: To	27. Manner of Death 28a. Date of (Month. D.	Injury 28b. Time of In		Subject shot	ow injury occurred	
Sion Attendi death. ctor: y the f	2 Accident Investigation Oct 19, 20	12 0148 hrs	1 Yes 2	No '		5 15 1 N 1 0
Division o spital or Attending hours after death. neral Director: After filled in by the fune Certification:	Suicide Could not be determined (Specify)	of Injury - At home, farm, street Parking Lot	r, ractory, office building, etc	or Town, St		Rural Route Number, City
	4 Memicide 29a. Certifier 1 Certifying Physician: To the best of Check only		ed at the time, date and pla			tated.
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of eand manner state			curred at the time, date a		
	29b. Signature and title of certifier		29c. License number O.C.M.E.		October 19, 20	
	30. Name and address of person who completed cause	of death (Item 23a)				
		Examiner 900 W. B	altimore Street, Balti	more, MD 21223		
State Registrar	31. Date filed (Month, Day, Year) 32. Regi:	strar's Signature	Kal			
DHMH 17 Rev 1/2001	HOI V = CUIC / Mar	ORIGINAL	72.77			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Day 24 20**1**2 Rae Ehrlich 1:00 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 081-18-2117 Director 1 □ M 2 □ F 88 10-29-1923 New York ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🖔 Yes 2 🗌 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 14508 Homecrest Road #421 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give ξ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours efter 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify: Completed WHite Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) 8'nai Brith Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked o a Frieda Rosenberg Joseph Leventhal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pege 1 end 2 sh ment of Health a tent: If item 27 is 14707 Stone Creek Court, Centreville, Virginia 20120 Neil Ehrlich - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State Department o Importent: If any injury or once. ò 1 K Burial 2 Cremation 3 Removal from State 10-28-2012 Adelphi, Maryland Donation 5 Other (Specify) Mt. Lebanon Cemetery ature of Funeral Service Licensee Lenard Kent Sign 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Esophageal Obstruction Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): is certificate has been signed by the attending physician and director, page 2 should be detached for use as the buriel-transit or Attending Physicien: The lew requires that the death certificete be executed Disseminated Esophageal Adenocarcinoma that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 篇 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed 2 \square No 2 X N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 Tes 2 🛛 No 1 Donatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident Investigation 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41 10.24.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Foster Rising Rid 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar NOV 0

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bonnie Lingle Elliott October 26, 2012 10:35P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9 Kilcolman Court Apt. 204 Baltimore County Timonium 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 489-38-6812 76 **Director** 1 M 2 K Jan. 06, 1936 Biggers, Arkansas 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Timonium 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Kilcolman Court Apt. 204 21093 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ♣ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 02 Baltimore County Govt. Registered Nurse å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Ralph Lingle Eloise Park Department of Health and Important: If item 27 is in any injury or other traumong. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Timothy M. Elliott (Son) 2511 Downshire Court Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State (Baltimore County) Dulaney Valley Menocial 1 Burial 2 Cremation 3 Removal from State Tuesday 4 Donation 5 Other (Specify) Timonium, Maryland Nov. 06, 2012 21. Signature of Funeral Segrice Deenseq Jeffrey I. Cair, Sr. CFSP 22. Name and Address of Facility.

Percental Alternatives Funeral and Cremation Center, P.A.

Lic. #000677 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Pnysician/ rteriosc disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physicien and for use es the burlal-transit or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Vaar Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 icate has been sig r, page 2 should E 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending he Funerel Director: After and a filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signate and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 1 2012 NOV 0 Registrar

12-07318 James Evans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physici		Decedent's Name (First, Middle,Last)		Date of Death Month	av Year	3. Time of Death
ledical Exam	ıner		City, Town, or Location of Death	September 2	24, 2012 4c. County of Death	0840 hrs
			avre de Grace	•	Harford	
Funeral			Under 1 Year If Under 24Hrs Ionths Days Hours Min		MM/DD/YYYY) 9. Birt	hplace (State eink
Director		1 <u>X</u> M 2 <u>F</u> 65 Yrs.	Ionuis Days Hours Will	June 13	, 1947 co	untry)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
E	<u>_</u>	MD Harford Aberdeen				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10	f. Zip Code	10g.	Citizen of What Cour	ntry?
th the l 23a or 20tified	ā	361 South Drive	21001		USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens and Canton for Health and Mental Hygiens and Canton for the manual, if item 77 is marked other than "natural", or items 23a, or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was De 1 Never Married 2 Married Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	æ					dire
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and 2 sho and 2 sho lealth and tem 27 is traumati		20a. Method of Disposition 20b. Place of Disposition			more, MD Oc. Location - City or	21201 Town, State
Baltimore, Department of Hee Important: Miter		1 Burial 2 Cremation 3 Removal from State crematory or other p	lace)			
altin mit. P partme portar ury or		4 Donation 5 Detret Specify: in State 21. Signature of Funeral Service Licenses 22. Name	and Address of Facility			
	L	Balti	Anatomy Board more, MD 2120)1		
Physician /Medical		23a. Pal I. Enter the dise se, or complications that caused the death. Do not enter the m failur. List only one cause on each line.	ode of dying, such as cardiac o	r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications of Chronic Alcoholism Due to (or as a consequence of):				Death
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	nine	if any, leading to immediate Due to (or as a consequence of):				
bd isit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Records, P.O. Box 68760, The law requires that the death certificate be executed care has been signed by the attending physician and page 2 should be detached for use as the burial - transit						
60, ate be shysiciz te buriz	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
687 certific ding p	lan/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal decedent pregnant at time of death 5 Others		ancy	Month D	ay Year
Box 687 c death certific the attending p	Physiclan/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	(Specify)			
s, P.O. B ires that the d signed by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		cco use contribute to	
Division of Vital Records, P.O. talor at a traction of Physician: The law requires that the tract and the tractor. After this certificate has been signed by led in by the funeral director, page 2 should be detacted.					2 No 3 Prob	
cords, law requir has been s	Completed			24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
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ttendi death. ctor: /	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Divising the price of the price	Certification:	3 Suicide 6 Could not be determined (Specify)	ctory, office building, etc.	28f. Location (Stre or Town, State		al Route Number, City
Lospita 4 hours funera		Z9d, Certifier 4 County in Description To the best of the least of the	at the time, date and place, and	due to the cause(s) and manner as state	ad .
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(check only one) 2 Medical Examiner: On the bast or my knowledge, death occurred a and manner stated.				
H 3 H 3	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Mor	th, Day, Year)
		Lin h. s	O.C.M.E.	S	September 28, 26	012
V		Name and address of person who completed cause of death (Item 23a) Ling Li, MD	treet Baltimore MD 21	223		
s	tate	31. Date filed (Month, Pay Year) 32. Registrar's Signature				
Regis						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 2perpHYS, G933, 11/1/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012_{ear} Physician/ Octobe LEON FLEMING 45 5 M Medical 4a. Facility Name (if not institution, give street and number) c. County of Death
PRINCE GEORGE'S 4b. City. Town, or Location of Death **Examiner** 10800 POOKEY WAY UPPER MARLBORO 5. Social Security Number Sex 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 12/21/1947 247-86-0376 64 SOUTH CAROLINA Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 XYes 2 No UPPER_MARLBORO PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Examiner must be Funeral 23a USA 20774 10800 POOKEY WAY items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or þ Yes, Give 2 No Army Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 K No Specify: 3 Divorced 4 Divorced Completed Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) HOME IMPROVEMENT PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ JULIA MAE SIMMON JOHN FLEMING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10800 POOKEY WAY UPPER MARLBORO, MARYLAND 20774 VIRGINIA FLEMING/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2012 RIVERDALE, MARYLAND RIVERDALE CREMATORY Signature of Funeral Service, Licensee J. B. JENKINS FUNERAL HOME, INC. ROAD HYATTSVILLE, MARYLAND 20785 LANDOVER 7474 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final las Heart Cardiovesen Physicant/ 05 cleno Tic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 2 🗌 No ed by the a detached 1 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed' death? 2 No Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examine ? Other: 2 🗌 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who commeted cause of death (Item 23a) (Type, Print) 300 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October FERRIS 10.15AM HYLLIS 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columb Howard 14 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 04/21/1926 New York 112-16-0963 Director 1 □ M 2 🖰 F 86 er than "natural", or items 23a or 28a-f show 10a. State 10b. Count 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Direct 1X Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6606 Windsor Court 21044 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Auctions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Garfinkel Sara Fuchs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie Urbont / Daughter 6606 Windsor Court, Columbia, MD 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medica! Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2/1 No Hospital: Other: 1 Tyes မ 1 / Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: (Month, Day, Year) Natural 5 Pending 1 Natural
2 Accident
3 Suicide work? 1 🗌 Yes 2 🔲 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bock River neck Road Essex Maryland 27221 Sabapathi 201-109 amesh

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

12-08072 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alpnzp Gladden State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar edent's Name (First, Middle,Last 2. Date of Death Physician/ **Medical Examiner** 2121 hrs 0120 Jr. October 24, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Days Hours Min oreign Director 216-21-3560 1 210 2 F Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 Ves 2 No Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 13s or 18s-f sho
injury or other transmatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10g, Citizen of What Country? Nagena 2122 Funeral 11. Marital Status Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 1 Yes 1 Yes 2 No specify: 3 Widowed Divorce Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nuclear 17. Father's Name (First, Middle, Last Alonzo Be onna (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 ဥ 19a. Informant's Name/Relationship (Type, Print) ntark OOK onna 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 rounsville Donation 5 Other Spe 21. Signature of Funeral Service Himore, MI Heights Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED #1, per me, g933 11-14-12 sm the attending physician and for use as the burial -UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other4 Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Oct 24, 2012 Subject shot 1 Natural 2040 hrs Pending 1 Yes 2 ✓ No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2900 Mallview Road, Baltimore, MD determined (Specify) Street

DHMH 17 Rev 1/2001 **OCME 2006**

ical

State

Registrar

29b Signature and title of certifier

31. Date filed (Month,

Patricia Arpnica-Pollak MD.

ORIGINAL

Assistant Medical Examiner

Registrads Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

OCME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimpre Street, Baltimpre, MD 21223

Year

29d. Date signed (Month, Day, Year)

October 25, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley C. Gesswein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOSEPH MEDICAL BALTIMORE TOWSON TEI Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign Maryland Feb. 24, 1920 212-14-3062 92_{Yrs} Director 1 □ M 2 🗓 F Usual Residence of Decedent show 10c. City. Town or Location deeth with the Maryland in then "natural", or items 23a or 28a-f sho 10d. Inside City Limits Parkville Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9514 Powderhorn Lane 21234 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ If Yes, Give Year or Dates. white 1 Yes 2 No Specify: 3 Midowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) At Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file hand Mental F Robert McCulley Jonnie Cornell Buchanan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1335 Potomac School Road-McLean, Virginia 22101 permit. Page 1 and 2 shk Department of Health an Important: If item 27 is any injury or other traus Sandy Kountz-niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery crematory or other place)
Evans Funeral Chapel
and Cremation Ser. Belair 1 Burial 2 K Cremation 3 Removal from State Forest Hill, Maryland Oct. 27, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ESPIRATORY Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate vause. Enter onderlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-trans To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Month Year Pregnant at time of death art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPOTHYROIDISM 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Hospital or Attending Physician: The 24 hours after death.Funeral Director: After this certificate b 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie only 29b. Signa ure and title of certifier who completed cause of death (Item 23a) (Type, Print) TOWSONIND 21200 32. Registrar's Signature State Registrar

SSWEIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Frances Josephine Gaist 8:54 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 5323 Saratoga Avenue Chevy Chase Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 578-16-2825 Director 1 M 2 X F 90 April 09,1922 Virginia Usual Residence of Decedent Pege 1 and 2 should be filed within 72 hours efter deeth with the Maryland anert of Heelth end Mental Hygiene. ans. If item 27 is marked other than "natural", or items 23a or 28a-1 show ant. If item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, the Medical Examiner must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase 1 Tes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5323 Saratoga Avenue 20815 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Gaist - Son 11521 Pleasant Meadow Drive, N. Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 11/02/2012 Rockville, Maryland Donation 5 Other (Specify) Menorah Gardens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lice 400709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. P. rt 1. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final weeks Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 15 Years <u>Coronary Artery Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician end s the buriel-trensit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760[°] IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown After this certificete has been signed by the etter funeral director, page 2 should be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Yes 2 X No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours a Funeral Medical 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certification

Robert H.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Blee. M.D..

"1 2012

29c. License number

D23556

5215 Loughboro Road, NW #440, Washington, DC 20016

29d. Date signed (Month, Day, Year)

October 31, 2012

AMEND 29D, PER MD 6933 11/1/12 TRT State of Maryland / Department of Health and Mental Hygieney 0 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:40P M 2012 JANE MARY GALLAGHER OCT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner HARFORD** BEL AIR UPPER CHESAPEAKE MEDICAL CTR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) May 6,1934 Months Country) 072-26-3006 **Director** 1 □ M 2(X) F 78 Vrs 100 Usual Residence of Decedent 10d. Inside City Limits or items 23a or 28a-f show 10b. County 10c. City. Town or Location Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🏝 No Abingdon 3.40 Pm Harford Maryland 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number Funeral 21009 USA 713 Shallow Ridge Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. was Decedent Ever in 0.5 Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Korean Year or Dates Orean Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: Specify: White 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mercy Medical Ctr. Medical Records Transcript 12 vrs. Vrs. allagher, Jane Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice J. Cote ပ Thomas J. Giroux permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 North Ave. Essex. Md. 21221 19a. Informant's Name/Relationship (Type, Print) Essex, Md. 1021 North Ave. Robert Gallagher (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition remetery, crematory or other place)
Holly Hills Mem.Grdn. 10-15-12 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fineral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2012 Immediate Cause (Final Physician/ 10 hours disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, October Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined City or Town, State) within 24 hours aft

To the Funeral Dir

completely filled in 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Fractitioner: To the basis of examination and/or, and only the cause of the c (Check 29d. Date signed (Month, Day, Year) Internal 29b. Signature and title of certifier 29c. License number OCT. 11, 2012 066136 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Ches: peaks heroly 500 Upper 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

		For State Registrar		Sta	ate o	f Maryl					ealth Death		lental Hy	/giene Reg. No	-711	112	34	784
_		Negistrar Decedent's Name	(First Middle	Last)					moat				2. Date of De		J		3. Time o	of Death
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/Medic		4a. Facility Name (If		give street	and nu	mber)			4b. City,	Town, or	Location		Бересш			of Death	1 . 24	LII
LAGIIIII	J1	Genesis	Homewo	ood					В	alti	nore							
Funeral		5. Social Security Nu	mber	6. Sex		7. Age (In	yrs. last birl	thday)	If Under	1 Year	If Under		8. Date of Bi (Month, D	rth	-1	9. Birth	place (State	
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afor after	Certification:	4 ☐ Homicide	determin	lied	buildi	ing, etc. (S _i	pecify)						City or To	own, Sta	ite)			
spita hours inera y fille		29a. Certifier	Certifying	g Physiclar	n: To the	best of my	knowledge	e, death	occurred	at the tir	ne, date a	ind place,	and due to th	e cause	(s) and n	nanner as	stated.	
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical	(Check only one)	2 Medical E	a	nd man	ner stated.									-			
Vith vith Com	Σ	29b. Signature and f	file of certifier			A 4			29	c. License	e number			29d. D	ate sign	ed (Month	Day, Year)	
) Cui	W D	reo		()	リ			D	004	170	56		10	, 18,	Z01	2
		30. Name and addre		who comple	led caus	se of death	(Item 23a)	(Type, P	Print)		1	7						
		31. Date filed (Mont)	t LIN	04120	122 5	(/ Segistraria	inasture	ME	1000	the K	tur	174	them	DUC	_ 2	1121	۷	
Stat Registra		NO\	0 1 20)12 /	ene	M /	8. A	ark					56					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12-07331 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Keith Michael Gobble State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** 0518 hrs September 28, 2012 Keith Michael Gobble 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Ceter Glen Burnie Anne Arundel 5. Social Security Numbelink 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 1 X M 35 2 1976 Maryland Yrs Dec 20. Usual Residence of Decedent 10b. County 10d. Inside City Limits any 10a. State 10c. City, Town or Location unk unk unk is 23a or 28a-f show are notified at once. 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
anti: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk unk USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14, Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Armed Forces? Married 2 X No Yes 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify. white ģ 16a. Decedent's Usual Occupation (Give kind of work done nk 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) boatyard 21215-0036 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Gobble Sandra Lee Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 949 Marzoff Road James Gobble/father Deale MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State timore, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: Signature of Fpneral Service Licen 28 Name and Address of Fagilit Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death a. Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, P. Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? page certificate Yes 2 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 this Residence 6 Other 1 🗸 Yes ۵ No funeral 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 Natural FOUND Division Yes 2 ✔ No Pending death. the Director: Sep 28, 2012 0445 hrs 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City filled in 3 6 Could not be Suicide or Town, State) Eastern St & Baltimore-Annapolis Blvd, Glen Burnie, MD determined (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E September 28, 2012

State 31. Date filed (Month, Day, Year, Registra

OCME

30. Name and address of person who completed cause of death (Item 23a)

Carol H. Allan, MD

NOV O

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar		partment of F			20	12	34786
			Registrar 1. Decedent's Name (First, Middle, L	.ast)		ortinoato or	Doutin	2. Date of De.	Reg. No.		3. Time of Death
	Physicia		william 1	11 7	ay			Month / O	Day 7	Year	125 AM
7	/Medic Examin		4a. Facility Name (If not institution, g	7 (0 0 1 1 2		4b. City, Town, o	r Location of		4c. County	- 1 -	.,
	LAGITIII	CI	Buckinghum	115 Choice		Adl	ums t	nun	F	ed.	ride
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthda	y) If Under 1 Year	If Under 24	4 Hrs. 8. Date of Birt Min. (Month, Da	h v Year)	9. Birthpla Count	ace (State or Foreign
	Director		059-22-7575	1X M 2□F 86	Yrs.	Months Days	Hours	Jan 25	1926	New	Jersey
	2		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or	Location				16	Od. Inside City Limits
	eho eho	5								10	1 Yes 2 No
1	28a-1	ect	MD Frede 10e. Street and Number	rick	Ada	mstown 10f. Zip Code			10g. Citizen of W	/hat Count	
	NILL N		3200 Baker Circ	1. H_026		217	710		USA	nat Count	ny i
1	ne 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 1:			n? (Specify Yes or No		- America	an Indian,
(0	in the man	F	1 ☐ Never Married 2 ☑ Married	Armed Forces?			an, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	Blac	k, White, e	
93	er's a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 152	-57	1 ☐ Yes 2 💢 No	Specify:		Specify	· wh:	ite
2-0	be lied within 72 hours after death with the Maryland klaf Hygiene. klaf Hygiene. do other them "natural", or flame 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. De	cedent's Usual Occup ve kind of work done	ation during most of	of working	16b. Kind of Bu	siness/Ind	ustry
2		npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retired	1)	g			
7	led w tygier her ti	ខ	12	5+	V	eterinaria		a Nama (Cint Middle			eseasrch
Maryland 21215-0036	ntal H	Be	17. Father's Name (First, Middle, Last William Doanle					s Name <i>(First, Middle,</i> thy Ingalls		3)	
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E	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Heelith and Mental Hygiene. Importment of the m27 is marked other then "natural", or frame 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		Millicent Gay/s			-		H-026 Adam	-		1710
altimore,	is 1 a of Heer trem of he		20a. Method of Disposition	l l		position (Name of rematory or other place	ce)	Date	20c. Location -	City or Tov	wn, State
Ë .	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 4 🖾 Donation 5 ☐ Other (Spec	Hemovai from State			1	1			
<u>=</u>	permit. Departri Importa any inju		21. Signature 4 Superal Survice Lig	munde Wrecto	r s	22. Name and Addre	ss of Facility	ard 655 W.	Baltimo	re S	treet
Δ :	82 5 3		(Knnn)	mee-		Baltimore,					
u			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dea ly one cause on each line.	th. Do not e	enter the mode of dyir	ng, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Pneumo	onia	•					Criset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):						
3	d ansit	Examiner	Cause (Disease or injury that initiated events	С.							
o,	en an urial-tr		resulting in death) Last	Due to (or as a conse	quence of):					,	
8760,	Attending Physician: The law requires that the death certificate be executed cleath. ector: After this certificate hes been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	lical		d							
9	attending pt	Med	IF FEMALE:	22. 1							
Bo	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of	al death	3 □Ectopic pregnancy	,		23d. Date Mor	e of deliver hth	ry Day Year
P.O. Box 6	by the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	oeatn :	5 ☐ Other (specify) _					
О.	mar ed by deta		Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contr	ibute to the	e cause of death?
cds	n signed k	d by	Dysphagi	a				11	Yes 2 No	3 🗌 Proba	ably 4 Unknown
00	s been si	jete	Parkinso	4 <				24a. Was	an 24b. V	Vere autor	osy findings available
æ }	te hes	Completed						— autop perfo	rmed?	leath?	opletion of cause of 2□ No
a	tifica tor, p	0	25. Was case referred to medical				26. Place of	of Death (Check only of		163	20140
>	ysic lis ce direc	ToB	examiner? 1 ☐ Yes 2 🔊 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpat	ient 3□ DOA Oth	er: 4/2 Nurs	sing Home 5 Resi	dence 6 Othe	ar (Specify)
0 2	fter th	ä	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur		y at k?	28d. Describe	now injury occurr	ed	
Sio	eath.	cati	2 Accident investigat			M 1□	Yes 2 □ N				
:	- 9	Certification:	4 Homicide determine	28e. Place of Injury - At h building, etc. (Spec	nome, farm, ify)	street, factory, office		28f. Location (Street and Numb vn, State)	ar or Rural	Route Number,
	ours ours nerel		29a. Certifier 1 🕅 Certifying I	Physician: To the best of my kn	owledge, de	ath occurred at the tir	ne date and	place, and due to the	cause(s) and ma	nner as st	ated
1	to the mosphelo or standarding Prysician. The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Ex	aminar: On the basis of examin and manner stated.	ation and/or	investigation, in my o	pinion, death	occurred at the time,	date and place, a	ind due to	the cause(s)
	withir To the comp	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, E	Day, Year)
•				mo		Do	5872	26	10-18	-201	Z
			30. Name and address of person wh				A4		A A : -		
	0.01		31 Date filed (Month Day Year)	MD 3000 -	D Ve	nthe CT:	My	ersville M	0 217	13.	
	Sta Registr		31. Date filed (Month Pax Year)	12 Sensus &	1. 400	ale					

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Adam Gaberiel Gu		0 I- For State	St	ate o	f Maryla	and / D	epartmer Certificate		Health an	d Me	ntal Hy	_	D N		2	3478
Physiciar	Registrar 1. Decedent's Nam	strar								2. Date of De	Reg. No. 2. Date of Death Month Day Year			3. Time of Death		
Medical Examine	-	Addit Of Sullo Dit								of Dooth	October	27, 20	012	nath	0012 hrs	
		4a. Facility Name (100 Ann Av		.itution, give street and number)				1	4b. City, Town, or Location of Death Essex					c. County of Death Baltimore County		ty
Funeral		5. Social Security N		6. Sex		7. Age (Ir	yrs. last birthda	ay)	If Under 1 Yea	_	der 24Hrs.	-		M/DD/YYYY) 9.	Birth	place (State or
Director		212-31-0		1 X	/ 2☐ F	2	22	Yrs.	Months Day	rs Hou	ırs Min.	04/2	1/1	990		atry) MD
any	-	Usual Residence o 10a. State	f Decedent 10b. County			100	c. City, Town or	Locati	on						1	0d. Inside City Limits
	٦	MD	Bal	timo	ore		E	Ss	ex							1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Nu							10f. Zip Code	24			10g. C	itizen of What (y?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiente. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she injury or other traumatite or ever, the Medical Examiner must be notified at once	- 1	100 Ani	i Ave.		12. Was Dec	edent Eve	er in IIS 1	3 Was	212 s Decedent of Hi		rigin? (Sp	ecify Yes or N	No-	US 14. Race - Ar		an Indian, Black,
eath w	unera	1 XNever Marri	ed 2 M	larried	Armed F				es, specify Cuba					White, et	C.	
after d	S E	3 Widowed			Yes, Give Yea or Dates:	ır			Yes 2 No				Lio	Specify: W.		
2 hours "natur		15. Decedent's Ed			highest grad		dur	ing mo	t's Usual Occupa ost of working life	DO NO	T use retir	red)		Kind of Busine		•
5-0036 iled within 77 Hygiene.	ompleted	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , ,		• .	ears		Foi	cklift 		_			Layher	Co	ompany
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2121 ould be fill Mental I marked	80									tine Braun Rural Route Number, City or Town, State, Zip Code)						
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ore, eslan of Hea If iter	1	20a. Method of Dis 1 Burial 2	<u>'</u>	n 3 🗌	Removal fr	om State	crematory	or oth		metery,	, ,	Date		altimo		
Baltimore, oemit. Pages I ar Department of He Important: If ite Important: If ite Important or other tr	-	4 Donation 5			9 1	7	Hol.	22. N	Hill ame and Addres	s of Facil		/2/12				21221
Bal Permi Depa Impo injur		21. Olyrialda	8	2	U	7			nnelly						3X	21221
Physician		23a. Part I. Enter the failure. List on				aused the	death. Do not e	nter th	ne mode of dying	, such as	cardiac o	r respiratory a	arrest, s	hock, or heart		Approximate Interval Between Onset and
Examiner	I	Immediate Cause (or condition resulti			forphi		ntoxicat	:101	n						-	Death
		Sequentially list co		b	ue to (oi as a	Conseque	erios or).								_	
	Examiner	if any, leading to in cause. Enter Under	nmediate erlying Cause		ue to (or as a	conseque	ence of):									
sd Isit	xan	events resulting in		Di	ue to (or as a	conseque	ence of):									
executed an and al - transi	dical	X UNPENDED		_ d Ծ	AMENDED	1,23a	1,27,28a	-f	per me,	g933	3 11-	15-12	sm.			
'60, zate be physici he buri	Med	IF FEMALE:			23c. If yes,	outcome o	of pregnancy						2	3d. Date of deli	ivery	
23b. Was decedent pregnant in the past 12 months?							Month Day Year									
Box e death o the atter ed for us	lysi	1 Yes 2			9 Unkn								1			(4.11.0
P.O. es that the igned by be detach	g P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												e cause of death? bly 4 Unknown		
ds, l	eted									24a. Was an autopsy findings avail prior to completion of cause						
BCOF te law r te has b	Completed							•	····				formed'	? deat	h?	
of Vital Records, and Physician: The law requint the this certificate has been someral director, page 2 should the state of the state o	0	25. Was case refer	red to medica	-					26.Plac		th (Check	only one)				
Physici ruthis o		examiner? 1 ✓ Yes 27. Manner of Dea	2 No	Ho	spital: 1 28a. Date	Inpatient	2 ER/Outp			other				dence 6 🗸 C	ther:	Scene
nding and the transfer of the function	cation:	1 Natural		ding	(Month	, Day,Year)				Yes 2				sed dru	g	
25. Was case referred to medical examiner? Hospital: 1 In the print of the prin							res 27–12 fd 12:01 am 1 res 22 No of Injury - At home, farm, street, factory, office building, etc.				28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 Ann Ave.					
Di spital hours a neral I	Certif	4 Homicide		ermined	(Specify)		Residenc					Essex	,MD			
To the Hos within 24 h To the Fu	Medical	(Check only	Certifying P	aminer:	On the basis	of examin	nowledge, death ation and/or inve	occur estigat	red at the time, o tion, in my opinio	ate and p n, death	place, and occurred a	due to the ca at the time, da	te and p	and manner as place, and due t	stated to the	ı. cause(s)
To roor	ğ	29b. Signature and	title of certifi		and manner s	stated.			29c. Licen	se numbe	er		290	d. Date signed	(Mont	h, Day, Year)
		Jam.	- a		- 1	300) er u		0.0	M.E.			0	ctober 27, 2	012	
		30. Name and add						er	900 W. Balti	more S	Street. B	Baltimore.	MD 2	1223		
Sta	te	31. Date filed (Mon				egistrar's	Signature									
Registr		NE	W 0 1	2012	De-	mar		4.4	العا			_				
DHMH 17 Rev 1/200	01			n	CME		ORIG	INA	L							

OCME

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Division of Vital Records, After this certificate has been in 24 hours after deau.

the Funeral Director: A'
the fine of the fire of the

Certification: To

Medical

-											
				24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 ☐ No						
25. Was case referred to medical	26 Place of Death (Check only one)										
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatient 3 DO/	ng Home 5 Residence 6 🗹 Other: Scene								
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)										
3 Suicide 6 Could not I determined	be 28e. Place of Injury - At hom	ne, farm, street, factory, o	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1 Certifying Physici	ian: To the best of my knowledge	, death occurred at the til	me, date and place, and	due to the cause(s) and r	manner as stated.						

and manner stated. 29b Signature and title of certifie

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 23, 2012

34788

1832 hrs

1 XX Yes 2 No

Approximate Interval

Between Onset and

Death

Year

me and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

To the 3 within 2 To the 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Phyllis Hester 5:58pm Month 1 26 2012 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth 219-52-6982 Days Hours (Month, Day, Year) 1 □ м 21 Е Director 11/18/51 Yrs Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location the Maryland 10d. Inside City Limits Funeral Director MD N/ABaltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21207 2535 Gatehouse Dr. Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black White, etc.
African
Specify: Amor 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Amer. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Housewife Self Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sydney Hester Elizabeth Harris 19a. Informant's Name/Relationship (Type, Print) Tanya Chase/Daughter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2535 Gatehouse Dr., Balt., MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If Ite any injury or otl once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 11/3/12 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Auner Service Lig 22. Name and Address of Facilit Hari P 22. Name and Address of FacilitHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ervical Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 🗗 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defice a Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29d. Date signed (Month. Day, Year) OCTO3-C 27 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G701 N. Charles MO N 31. Date filed (Month, NO 37. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17,18&20a-c Per FH G933 11/07/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ochoper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balhmere andalls town 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) If Under 24 Hrs. If Unde 8. Date of Birth **Funeral** Months 2.4815 77 NY Yrs. 1935 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "---" 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Baltimore Baltimore MD 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 070B Stonington Avenue 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🗹 No Specify: Black 3 🗆 Widowed 4 🗀 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Scume 12th grade Garnsey Lithographic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edgar Howard Ethel Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Henr (WIFE) 5706 Stunington Allenute Baltimore MD21207 Margaret 20b. Place of Disposition (Name of Crematy ionato Genteriace) 20a. Method of Disposition 20c_Location - City or Town, State Hanover, MD 11/06/2012 TXBurial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12012 Moodlaway MD Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licenses 22. Name and Address of Facility aughn 87Z8 Road Randallstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ TROTAKY arking utherosclerone cuais disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed perlipsed as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2. No Hospital Other: 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatule and title of certifier, 29c. License number Ochber 28, 2012 006595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

filed (Month, Day, Year,

2012

old Court

5401

32. Registrar's Signature

Randalishum, MD 21133

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ October 20°12 11:45 Shannon Michelle Hawkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 707 S. President St; Apt 1512 Baltimore Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 220-02-5664 Director 1 M 2 XF Jan 9, 1969 43 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral 707 S. President Street #512 21202 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black White etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry المالية. *عا Hygiene. معادلتات Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the director's assistant movies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Hawkins Carolyn Costa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 707 S. President Street #1409 Baltimore, MD 21201 Anthony Hawkins/father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) □ Burial 2 □ Cremation 3 □ Removal from State 4 X Donation 5 ☐ Other (Specify) Rona d 8. ²². Name and Address of Facility. State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ancer Breast disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Specify) Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Maprier of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hound to the sound to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature at ျ

Registrar

DHMH 17 Rev 06-2011

State

MO

ess of person who completed cause of death (Item 23a) (Type, Print)

AMUEL

- NON+H

31. Date filed (M

6701 N , Cerazies ST TOWSON MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Of Ma	_	epa rtment of Certificate of		Mental Hy	giene	0 01700
			Decedent's Name (First, Middle, Last)		A	Death	2. Date of Dea	Reg. No. 2	3. Time of Death
	Physici Medi		CHARLES H	ARKET			Month	15 201	2 1.10 P M
	Exami		4a. Facility Name (if not institution, give street and number)			or Location of Dea	th	4c. County of I	
-	/		Sanctuary at Holy Cross 5. Social Security Number 6. Sex 7. Age	(In yrs. last birth	Burton	sville I If Under 24 Hrs		Montgo	
	Funeral Director		333-20-4720 1 M 2 □ F		Months Days	Hours Min	. (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	, MC		Usual Residence of Decedent	09	rs.		June 1	5, 1923	Illinois
	ryland -f sho	ctor	10a. State 10b. County	10c. City, Town				1	10d. Inside City Limits
	ie Ma r 28a notif	Dire	MD Montgomery 10e. Street and Number	Silv	ver Spring				1 Tes 2 No
	with the 23a cast be	aral	17310 Quaker Lane C25		10f. Zip Code	860		10g. Citizen of What	t Country?
	eath v	Fun	11. Marital Status 12. Was Decedent E	ver in U.S.	13. Was Decedent of H	lispanic Origin? (S	pecify Yes or No-		American Indian,
39	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Nover Married 2 Natural Armed Forces? 1 Nover Married 1 Natural Natu	No	If Yes, specify Cubate 1 ☐ Yes 2 🛣 No		to Rican, etc.)	Black, V	Vhite, etc. White
21215-0036	hours natur dical l	lete	15. Decedent's Education		Decedent's Usual Occup			16b. Kind of Busine	
21	within 72 giene. er than " , the Med	omp	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-4	- 6	Give kind of work done ife. DO NOT use retired)	during most of wo	rking		ood maddily
	d with Hygier ther t	BeC		m	anager			propert	ies
Maryland	should be filed n and Mental Hy 7 is marked oth raumatic event	10	17. Father's Name (First, Middle, Last) Herbert Charles Herbaert Harker Si	-			me <i>(First, Middle, I</i> ae Jackso	-/	
ary	hould and M s mai umat		19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address (Street				Zin Code)
	nd 2 s salth a n 27 i er tra		Eleanor Harker/spouse		310 Quaker				
ore	re 1 ar t of He Miter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of E	Disposition (Name of crematory or other place	1	Date	20c. Location - City	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 🕅 Donation 5 🗆 Other (Specify)						
B	permir Depar Impor any in		Jamn//lell		22. Name and Addre State Ana Baltimore	MD 21	201	_	re Street
			23a. Part Lenter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	he death. Do not	t enter the mode of dyin	g, such as cardiad	or respiratory arre		Approximate Interval Between
-	Medical		Immediate Cause (Final disease or condition resulting in death)	17/5/17/7		DSTATE	CANC	E	Onset and Death
-	Examiner		Due to (or as a	consequence of)					1
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	ificate be executed g physician and as the burial-transit	al E)		consequence of):					
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	ath certific attending for use as	n/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of	pregnancy				00101	
Вох	e atter	sicia	1 Yes 2 No 4 Pregnant at t	Fetal death ime of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	У		23d. Date of Month	Day Year
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<u>۳.</u>	requires that the death been signed by the atter should be detached for	by	Part II. Other significant conditions contributing to death but	not resulting in t	the underlying cause give	en in Part I.			e to the cause of death?
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ecc	e law has l	Completed	HNH SHN SH				24a. Was a autops perfori	sy prior	autopsy findings available to completion of cause of
<u>~</u>	in: Th ificate tor, pa		25. Was case referred to medical		00 PI	(D	1 🗆 Yes		Yes 2 No
Ĭ.	ysicik is cert direct	To Be	examiner?	t 2 ER/Outo:	atient 3 DOA Othe	ace of Death (Chec		ence 6 🗆 Other (Sc	
of	ding Physician: The la h. Affer this certificate he funeral director, page	ite:	27. Man of Death 28a. Date of injury (Month, Day,	28b. Tim	ne of 28c. Injury	at		w injury occurred	эвспу)
ioi	Attendi er death. ector: A by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2 No			
Division of Vital Records,	I or Attending I after death. Director: After din by the funer		4 Homicide determined 28e. Place of Injury building, etc. (- At home, farm, Specify)	, street, factory, office		28f. Location (St. City or Town	reet and Number or a n, State)	Rural Route Number,
	of the Hospital or Attending Physician: The law requires that the death certifully within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 14 Certifying Physician: To the best of m	y knowledge, dea	ath occurred at the time	, date and place,	and due to the cau	use(s) and manner as	stated.
:	To the H within 24 To the Fi complete		only one) 3 Certifying Nurse Practitioner: To the basis of exa	mination and/or in	dge, death occurred at the	n, death occurred a ne time, date and p	at the time date an	d place and due to th	ne cause(s) and manner stated
	₽ ≥ ₽ 8		29b. Signature and title of certifier		29c. License	number 8595	2	9d. Date signed (M)	nth, Day, Year)
		}	30. Name and address of person who completed cause of dea	th (Itary 00) 7		100 17		10/15/1	
			TASNEEM LAKHAM	, mi)	PDBDX	1525	DWING	TS MILL	m) 20117
	Stat Registra	~	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	Kad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANLE UBBARD) 16M 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death County of Death Prince George's 6916 Northgate Parkway Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min (Month, Day, Year) **Director** 1 XM 2 □ F 463 62 7843 71 Oct 29, 1940 Texas Usual Residence of Decedent or 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified Prince George's 1 Yes 2 No Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 6916 Northgate Parkway 20735 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ₩Widowed 4 □ Divorced Specify: Black Completed Year or Dates. 1959–1962 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Union International Representative Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virginia Byars Raymond Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Onslow Way, Capitol Heights, MD 20743 Stanley Hubbard, Jr. (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Resurrection Cemetery Nov 2,2012 Clinton, MD 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Lee Funeral Home, Inc 6633 Old Alexandria Ferry Read, Clinton, MD 20735 Kennet 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical disease or condition UNTH resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Other (specify) Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗆 Yes Completed 2-No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 06-2011

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JDay JU 605 201 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** Beltimore Medstan HARBOR 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours 217-40-0126 1 ☐ M 2 ☐ F 69 County aryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Director notified 28a-f 1 Yes 2 No Glen Burnie Hrundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be r Funeral 208 Baylor Road 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 ☐ Yes 2 🗷 No Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural" Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) ulth and Mental Hygiene.
27 is marked other than r traumatic event, the M Elementary/Secondary (0-12) Carpenter Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Joseph Hadaway Christine Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Jeffrey W. Hadaway / Son 11762 Sherman Street, Northglenn, CO 80233 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Chesapeake Crematory 10/27/2012 Beltsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall (Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ WRRKS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2XNo 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) Certificate: 28c. Injury at 28d, Describe how injury occurred injury work? 1 🔲 Yes 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 074532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Soul b Hanover MA 32. Registra Signature State

X DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28 2012 Month 10 Mildred B. Haag 1:00 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Funeral Days Min. 92 173-14-4350 Director 1 □ M 2X F 5/6/1920 PÁ Usual Residence of Decedent 27 is marked other then "neture!", or items 23e or 28e-f shov treumetic event, the Madical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkton MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21120 USA 10 Lauriann Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hyglene. Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pege 1 and 2 should be file Depertment of Health end Mentel I Importent: if Item 27 is marked o eny injury or other treumetic eve Catherine Parks Paul Biddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Daniels (daughter 3417 Heather Drive York, PA 17408 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11/2/12 Baltimore, MD Holly Hill 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Essex 300 Mace Avenue Baltimore, MD 21221 23a. Part 1. Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last physiclen end s the buriel-transi Due to (or as a consequence of): Physician/Medical The lew requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 器 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 1 ☐ Yes 2 😿 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 🗌 Yes 2 🗍 No Director: A log in by the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNP 2300 DULANEY VALLEY RD. TRACIE L. MORGAN / CRNP TIMONIUM, MD 21093 State Registrar

a.m.

2012

Diana Marie Hendricks

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Funeral		5. Social Security Numb	er	6. Sex	7. Age (I	n yrs. last	birthday)		r 1 Year	If Under		8. Date of Bir	th(MM/DI		9. Birth Foreign	place (State or	
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Baltimore, oemit. Pages 1 an Department of Hea Important: If iten injury or other tr	- 1	1 Burial 2 X C			from State		matory or oth runde			r.,	Oct	28 12	046	ento:	n. N	Maryland	
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Dep Dep Injury	-	1 1/1/1/	6	111		M007	73 3	.3 Ta	albot	t Av	e.,	Home, Laurel	, Ma:	ryla	nd 2	20707-43	
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ospita hours uneral		4 Homicide 29a. Certifier 1 Cer		nysician: To the	fy) Fd:R			red at the	time dat	te and pla					-		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director.	Medical		dical Exa	miner: On the bas and manne	is of examin	nation and	or investigation	ion, in m	y opinion,	death oc	curred at	the time, date	and plac	e, and du	ue to the	e cause(s)	
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			For State Registrar	State of IVI	aryiand / Dep <i>Ce</i>	artment of F rtificate of L		i Mentai Hy	giene 2 U	12 34/9/
		,	Decedent's Name (First, Middle, Last)					2. Date of De	eath	3. Time of Death
e	Physicia Medi		James Louis John					Septem	ber 19,	2012 7:44 PMM
	Examir	er	4a. Facility Name (if not institution, give si	,		4b. City, Town, or		ath	4c. County	
-	Funanal		Alterra Clare Br. 5. Social Security Number 6. Sex	_	age (In yrs. last birthday)	Hagerst If Under 1 Year	If Under 24 H	re O Dot- of Bi-		nington
	Funeral Director			M 2 □ F	82 Yrs.	Months Days	Hours Mi	n. (Month, Da	ıy, Year)	Birthplace (State or Foreign Country)
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	nyland I-f sh	cto	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	ne Ma or 28a notif	Dire	MD Washing 10e. Street and Number	ton	Hage	rstown 10f. Zip Code			40 011	1 Yes 2 No
	with the 23a c	eral	14707 Strite Road				742		10g. Citizen of USA	what Country?
	teath tems er mu	Funeral Director	11. Marital Status	2. Was Decedent E	ver in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No-		e - American Indian,
36	after o	ρ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give	No	r yes, specify Cuba 1 □ Yes 2 😿 No		erto Rican, etc.)	Dia	ck, White, etc. • white
5-00	hours "natur dical E	plete	15. Decedent's Edu (Specify only highest grad	Year or Dates.		dent's Usual Occupa		orkina		usiness/Industry
21215-0036	ithin 72 ene. r than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+) life. D	O NOT use retired)	uning most or w	Orking	0.07771	tor agions
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lan	should and h is ma	Ji,	19a. Informant's Name/Relationship (Type		1.1	ng Address (Street a				State, Zip Code)
	and 2: lealth em 27 ther tr		Donna johnson/spo	use)7 Strite	Road H	agerstown	1, MD 2	1742
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	111	20b. Place of Dispo cemetery, crei	sition (Name of natory or other place	e)	Date	20c. Location -	- City or Town, State
Bal	permit Depar Impor any in		21. Sign to a Sunoral Service Licenses	nu		Baltimore	, MD	21201		more Street
Ρ			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	cations that caused cause on each line	0.1				rest,	Approximate Interval Between
-	Physical Medical	i	Immediate Cause (Final disease or condition resulting in death)		patocello	lar (arcin	sma		Onset and Death
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8760	ificate ng phy as th	Med	IF FEMALE:							
89 x	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	у			te of delivery
Box	he dea y the a ached f	Physician/Medical	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 L	Other (specify)			Mo	nth Day Year
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Division of Vital Records,	ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,	y 28b. Time of	28c. Injury works	at	_	ow injury occurre	
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	Norit		29b. Signature and title of certifier			29c. License	number) 544.		49 4 4	(Month, Day, Year) - 18, 2012
			30. Name and address of person who con	- 11	ath (Item 23a) (Type, F		on this be	Mar.	land	
b	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 1 2012	32 Registra	's Signature	Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22, 2012 Physician/ Month CTOBER Diane Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SAINT JOSEPH OWSON 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 214-58-5852 61 1 🗆 M 2 💢 F 01 04 51 MD 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 U.S.A. 1216 Walters Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ X arried ğ 1 Yes 2 YNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: OLLOWAY, DIMNE 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12)
10th grade College (1-4 or 5+) School Bus Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Barry Warner L. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Importent: If item 27 is eny injury or other trau once. 6697 Loch Hill Road, Baltimore, Md 21239 Robert A. Jones-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Removal from State 4 Donation 5 Other (Specify) Memorial Park 10/31/12 King Woodlawn, Md 21. Signature of Funeral Service Licensee March For Fowerst 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the dis Approximate Interval Between Onset and Death VEEKS ase, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, coa. Part 1. Enter the gisease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final) disease or condition resulting in death) NGL Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami isigned by the attending physician and Id be detached for use as the burial-transit The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, cate has been siç r, page 2 should t Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No an 24 hours after death.

the Funerel Director: After this certificate I
apletely filled in by the funeral director, pag Hospitel or Attending Physiclen: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗎 No 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I complet only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 123/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 DAVID A. BRINKER, M.D. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner PERRY YOIN VA MARYLAND HEALTHCARE SYSTEM 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 215-32-3767 Director 1 🛛 M 2 🗆 F 88 02/24/1924 New Jersey parmit. Pege 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hyglane. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Evanther must be notified at any Injury or other treumatic event, the Medical Evanther must be notified at any Injury or other treumatic event. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 McNamee Lane, Apt. 214 21911 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Boiler Maker Manufacturing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Bloomfield Meyer Peter Jensen Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estelle C. Jensen / Spouse 100 McNamee Lane, Apt. 214, Rising Sun, MD 21911 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 10/30/2012 Hanover , Maryland 21. Signature Funeral Service Litensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) NKNOWN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: Tha law raquiras that tha daath cartificata be axecuted within 24 hours aftar death.

To the Funeral Director: Aftar this cartificate has baen signad by tha attanding physician and complately filled in by tha funeral diractor, page 2 should ba dateched for usa es tha burlai-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 40 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 TYes æ 25. Was case referred to medical 26. Place of Death (Check only one) exarriner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Suppatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed duse of death (Item 23a) (Type, Print) DIOWOO, M.D. VA MARYLAND HEALTHKARE SYSTEM, PERRYDOINT MD our 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 NOV 0 Registrar

2-08033 erome Bernard	Jer		or Print in B						•	10 010
		1- For State Registrar	e or Maryland			Death	io Meritari		∠ U Reg. No.	12 3480
Physicia	ın/	1. Decedent's Name (First, Middle, L	,					2. Date of De Month		3. Time of Death
Medical Exami	ner	Jerome Bernard						October :	23, 2012	1225 hrs
		4a. Facility Name (if not institution, 334 South Bouldin Street		r)	ľ	4b. City, Town, o Baltimore	r Location of Dea	ath	4c. County of De	eath
Funeral				ge (in yrs. last b	oirthday)	If Under 1 Ye	ar If Under 24H	Irs. 8. Date of B	irth(MM/DD/YYYY) 9.	Birthplace (State or
Director		212-58-1130	K M 2 F	60	Yrs	Months Da		lin.) IFo	reign
		Usual Residence of Decedent						F-1		Country) Maryland
м апу		10a. State 10b. County		10c. City, Tov	vn or Locati timor					10d. Inside City Limit
rland -f sho	ğ	Maryland		Dai	CIMOI					1 X Yes 2 N
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 334 South Bould	din Street			10f. Zip Code 2122	4		10g. Citizen of What C	ountry?
ith the 123a c		11. Marital Status	12. Was Deceder	at Ever in U.S.	13 \/\/a	s Decedent of H	ispanic Origin? (Specify Ves or N	U.S.A.	nerican Indian, Black
eath w	Funeral	1 Never Married 2 Marri	ed Armed Forces				in, Mexican, Puer		White, etc	.
after d	by F	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates:	Z ZX NO	1	Yes 2 X N	o s <i>pecify:</i>		Whi Specify:	ce
hours natur	뒿	15. Decedent's Education (Specify	only highest grade co				ation (Give kind o		16b. Kind of Busine	ss/Industry
36 iin 72 han "	툂	Elementary/Secondary (0-12) 12	College (1-4 or	r 5+)	_	enter		,	Constru	ction
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, La	st)	_			18.Mother's Nar	ne (First, Middle,	Maiden Surname)	
215 be file ntal H	Be	Jerome B. Jerom	in				Madel	ine Pane	ek.	
D 21 hould nd Me is ma	ျ	19a. Informant's Name/Relationship		Ţ	9b. Mailing	Address (Stre			mber, City or Town, St	
MD 2 shc salth and 2 shc salth and 2 shc sm 27 is raumati	1	Jerry Jeromin 20a. Method of Disposition	Son	20h Bloo		uliet L	ane 303		gham, MD 2	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	-	1 Burial 2 X Cremation	Removal from S	tate crem	atory or oth	er place)		Oct 29	1	
timent rtment	-	4 Donation 5 Other Speci 21. Signature of Funeral Service Lice				rematory		2012	Baltimor	e,MD
Bal permi Depa Impo	ļ	21. Signature of Pureral Service Lio		M0093		Kaczorow 1201 Dun	ski Funer dalk Aver	al Home, ue Balti	P.A. more Maryla	nd 21222
Physician	┪	23a. Part I. Enter the disease, or cor	nplications that caused	d the death. Do						Approximate Interva
/Medical Examiner	-	failure. List only one cause on Immediate Cause (Final disease	Atheroscl	erotic	cardi	ovascu1.	ar Disea	Se		Between Onset and Death
LAGIIIIIGI	İ	or condition resulting in death)	Due to (or as a cons							
	ا <u>ه</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of);					_	
	miner	(Disease or injury that initiated	B							
- =	×Ι	events resulting in death) Last	Due to (or as a cons	sequence of):						
ox 68760, ant certificate be executed attending physician and ou use as the burial - transi	Physician/Medical E	X UNPENDED	AMENDED 23a	a,27,per	me,g	3933 11-	5-12 sm			
'60, ate be ex ohysician	₽ŀ	IF FEMALE:	23c. If yes, outco	me of pregnanc	y				23d. Date of deliv	rery
687 certific nding	an,	23b. Was decedent pregnant in the past 12 months?	1 Live birth	t time of death	- =	al death 3	Ectopic pregr	nancy	Month	Day Year
Box 68760, a death certificate be the attending physic ed for use as the burner of the burner as the	Sic	1 Yes 2 No 9 Unknow	' Lau	t time of death	5 Oth	er (Specify)				
O. B. at the de de de tached f		Part II. Other significant condition	contributing to deat	th but not resulti	ing in the ur	nderlying cause	given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ires that the signed by	b b							1 Ye	s 2 No 3 P	robably 4 🗹 Unknown
ords w requi	Completed							24a. Was auto		autopsy findings available o completion of cause of
Reco	Ē								ormed? death	?
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sided in by the fineral director, page 2 should be a proper or the fineral director, page 2 should be a proper or the fineral director.	Be C	25. Was case referred to medical examiner?				26.Plac	e of Death (Check			
Physic Physic r this al dire	인	1 Yes 2 No			Outpatient				Residence 6 🗸 Ot	ner: Scene
n of ding Pl h. After	ᇹ	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Inju (Month, Day,)	ury 28b Year)	. Time of In		ry at Work? Yes 2 No	28d. Describe	how injury occurred	
Atten Atten r deat by the	<u> </u>	2 Accident Investiga	28e Place of Ir	njury - At home,	farm street			28f Location (Street and Number or	Rural Route Number, City
Ital or us after Iled in	Certification:	3 Suicide 6 Could no determin	t be	,, ,lome,	, 0000	., .a.c., , omce	anding, ott.	or Town, S		
	ल्	29a. Certifier 1 Certifying Physic							se(s) and manner as s	
To the within To the compl	8 −	29b. Signature and title of certifier	and manner stated.			29c. Licens			29d. Date signed (#	
		Cause H	00000			O.C.	M.E.		October 24, 20	

State 31. Date filed (Month, Day, Year)
Registrar NOV 0 1 2012

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL OCME

Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav **∕**lonth Year Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death Examiner 4c. County of Death imaritan Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 212-48 Months Days Hours Min. Director 1 NM 2 I F Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland iral", or Items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director zHimsle 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21200 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☑ No
If Yes, Give
Year or Dates. A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kochele. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) 10 21. Signatury of Funeral Service Livens. tome wyeral timore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Myocardial Medical Due to (as a consequence of): ∕Examiner extension Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transli Congestive that initiated events resulting in death) Last Due to (of as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Holiknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ☑ No ဍ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) **Medical** 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0062689 Kuthleen I Stret October 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

hele John

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12-08087 Paul Kittle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 34802

	1- For State Registrar	otate of Maryland	Certificate			Reg. No.	2 3400
Physician/ Medical Examiner	Decedent's Name (First,	Middle,Last) WILLIAM	KITTLE	- SR.	2. Date of Month Octobe	Death Day Year er 25, 2012	3. Time of Death 0959 hrs
The state of the s	4a. Facility Name (if not inst Upper Chesapeak	titution, give street and number) e Medical Center		4b. City, Town, or Lo	ocation of Death	4c. County of Deat Harford	th
Funeral Director	5. Social Security Number 438 – 31 – 852	.7 1XM 2_F	(In yrs. last birthday	Months Days	House Litin	of Birth(MM/DD/YYYY) 9. Bi - 21 – 1965 Co	
nd show any ice.	Usual Residence of Decede 10a. State 10b. Co MD		Oc. City, Town or Lo		E RIVER		10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Number 5 ALLOY CI	RCLE		10f. Zip Code	1220	10g. Citizen of What Cou	-
E . B	11. Marital Status 1 Never Married 2 3 Widowed 4 X	Married 12. Was Decedent E Armed Forces? 1 Yes 2 Divorced If Yes, Give Year	X No		anic Origin? (Specify Yes of Mexican, Puerto Rican, etc. specify:) White, etc.	rican Indian, Black, $WHITE$
36 iin 72 than '	15. Decedent's Education Elementary/Secondary (0	(Specify only highest grade composition) College (1-4 or 5-1)	durin	dent's Usual Occupatio g most of working life. [DISABLE]		16b. Kind of Business	•
21215-0036 ould be filed within 7 l Mental Hygiene. s marked other than it event, the Medica To Be Comple	HARRY	DAVID K	ITTLE	18	B.Mother's Name (First, Mide JUDITH	dle, Maiden Surname) UNKN	OWN
e, MD 21: 1 and 2 should the Health and Merite and Merite and merite and retraumatic every retraumatic events.	LESLIE ANN	tionship (Type, Print) COUS	143	RODEO CI	IRCLE MIDE	Number, City or Town, Stat DLE RIVER,	MD 21220
Baltimore, pemit. Pages 1 and Department of Heal Important: If iten injury or other tra	20a. Method of Disposition 1 Burial 2 Crem 4 Donation 5 Oth 21. Signature of Furroral Se		e crematory of METRO	position (Name of ceme other place) CREMATORY	10-30-1	20c. Location - City of CATONSV	ILLE, MD
	58	se, or complications that caused the	1	211 CHESA	ACO AVE RO	SEDALE, MD	
Physician Medical Examiner	failure. List only one c Immediate Cause (Final dis or condition resulting in dea	ause on each line. ease a. Narcotic ((Heroin)]			y arrest, shock, or flear	Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. From Underlying C.	Due to (or as a consec	quence of):				
cecuted tead transit	(Disease or injury that initia events resulting in death) L	Due to (or as a consec					
60, ate be execut obysician and he burial - tra	X UNPENDED			f,per me,g	933 11–20–12	Sm 23d. Date of delive	
D.O. Box 6876 that the death certificat ned by the attending ph detached for use as the by Physician/W	IF FEMALE: 23b. Was decedent pregnan past 12 months? 1 Yes 2 No 9	t in the 23c. If yes, outcome 1 Live birth 4 Pregnant at ti 9 Unknown	2 🗌	Fetal death 3 Other (Specify)	Ectopic pregnancy		Day Year
i, P.O. Erres that the case signed by the be detached do by Physical by Physic	Part II. Other significant co	contributing to death	but not resulting in th	ne underlying cause giv	en in Part I. 23e. [Oid tobacco use contribute to	
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific is after death. **In Director: After this certificate has been signed by the attending post in by the funeral director, page 2 should be detached for use as the effication: To Be Completed by Physician/					1 V		
Vital iysiclan: iysiclan: i director	25. Was case referred to me examiner? 1 Yes 2 No	Hospital: 4 Janetian	t 2 🗹 ER/Outpati		f Death (Check only one) ther4 Nursing Home 5	Residence 6 Othe	er:
ion of Virtending Physicath. tor: After this the funeral dir	27. Manner of Death 1 Natural 5 2 Accident	Pending Investigation 28a. Date of Injury (Month, Day, Yei	28b. Time 5-12 fd8:3		at Work? 28d. Described unknown	ribe how injury occurred	
Division of Vital Rec To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	3 Suicide 6 X 4 Homicide	Could not be determined (Specify)		treet, factory, office bui	or Tov	on (Street and Number or R wn, State) 2107 Morg wood, MD.	ural Route Number, City
To the How within 24 h To the Fur completely	29a. Certifier 1 Certifylione) 2 Medical	ng Physician: To the best of my Examiner: On the basis of exam and manner stated.	knowledge, death od ination and/or invest	curred at the time, date igation, in my opinion, o	e and place, and due to the death occurred at the time, o	cause(s) and manner as sta date and place, and due to t	ited. he cause(s)
	29b. Signature and title of c	ertifier wholly		29c, License O.C.M		29d. Date signed (McOctober 26, 201	
$\langle \! \rangle$	Laron Locke MD.	erson who completed cause of de Assistant Medical Exar		Baltimore Street,	Baltimore, MD 2122	3	
State Registrar	31. Date (ie) Wooth, Day	(ear) 32. Registrar's	s Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 11:40 PM enne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death 1ARIS EELL imonium Limore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Min (Month, Day, Year) 85-16-5867 Director 1 DM 2 1 F 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MI 1 Yes 2 No imore Apt. 3 05 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1600 2121 venue a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates Specify: 1 Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) aitress Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ 27, 2012 Vani 19a. Informant's Name/Relationship (Type, Prifit, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HIMURE MD 21229 Jaa 000 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 simore OCTOVER 4 ☐ Donation 5 ☐ Other (Specify) 3-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility hn 28 MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) END STAGE LIVER DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injuly that initiated events Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be execut Due to (or as a consequence of): resulting in death) Last physician a the burial Physician/Medical Records, P.O. Box 68760 ed by the attending I detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death PAULINE KENNEY 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown After this certificate has been signed by 1 funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Nes No Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a Was an autopsy 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE ဂ္ 1 ☐ Yes 2 😿 No 1 Inpatient 2 I ER/Outpatient 3 I DOA hin 24 hours after death.

the Funeral Director: After this
πpletely filled in by the funeral ι 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 ី Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signature and title of certif 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **CRNP** 2300 DULANEY VALLEY RD. MORGAN, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 32. Redistrar's Signature NOV 0 Registrar

12-08101 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Knellinger State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 26, 2012 0329 hrs Medical Examiner Michael Knellinger 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c County of Death Baltimore Harbor Hospital Center 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours Director 1X M 2 F Country) 57 218-68-9578 09/12/1955 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1339 E. Patapsco 21225 U.S.A. Avenue uneral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: 3 Widowed Specify: White à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 hont of Health and Mental Hygiene. Baltimore, MD 21215-0036 12 Machine Operator Binding 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Kenneth Knellinger Nancy Kahrs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Knellinger / Spouse 1339 E. Patapsco Ave., Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify Anatomy Gifts Registry 10/31/2012 Hanover, Maryland 21. Signature of Funeral Service Noons 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and Medical Death Immediate Cause (Final disease a Fentanyl Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g933 11-14-12 sm X UNPENDED attending physician for use as the burial Box 68760. IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed Yes 2 V No certificate Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Other4 Nursing Home 5 Residence 6 Other: this 1 Ves 2 No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 1 Yes 2 X No Director: unknown within 24 hours after death.

To the Funeral Director: 5 Pending fd 10-26-12 | unknown AM 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) 1339 E. Patapsco Ave determined Baltimore,MD (Specify) Fd:Residence Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) October 26, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrary Signatu

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2012 12:35 **ESTELLE** KREINIK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE **BROADMEAD** COCKEYSVILLE Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. Country) 089-07-4825 **Director** 1 M 2 X F Yrs. 94 07/21/1918 NY Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😿 No MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō rral", or items 23a o Examiner must be Funeral 13801 YORK ROAD 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 24 No Black, White, etc. ģ 1 Never Married 2 Married Yes Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give "natural" Completed 3 Vidowed 4 Divorced WHITE Year or Dates 27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ KREINIK MANUFACTURING OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ STACK DOROTHY JOSEPH FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS KREINIK/SON 1718 AVERY STREET, PARKERSBURG, WV other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 10/31/2012 MOUNT OLIVET CEM. PARKERSBURG, WV of Funeral Service, icense 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) NOU Medical as a conseque ic of): Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician doe detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contribuţing to death but not resulting in the underlying cause given in Part I. Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy Yes 2 Hospital or Attending Physician; Be 25. Was case referred to / edical 26. Place of Death @ eck only one) examiner? 2 **I**No Other: 1 🗌 Yes ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending on Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Voar Doris Erminia Kiesel 5:15 Ditaher 2012 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Summit Baltimore Y'ci a tonsville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Month: 216-12-9853 89 Director 1 □ M 2 🔀 F July 10, 1923 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Baltimore Arbutus 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1231 Ten Oaks Road 21227 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XXVidowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Secondary (0-12) 8th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herman Schultheiss Pauline Hand 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1329 S. Charles St. Baltimore, Maryland 21230 Roger Dietrich / Son Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Nov. 6,2012 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 22. Name and Address of Facility AMPROSE FUNERAL ROME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 106 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physicina/ Pancreadic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be execute 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🔲 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending 2 🗆 No Investigation 6 ☐ Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 16275

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1308r

31. Date filed (Month, Day, Year) NAV 0 1 2012 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 2933 11-1-12 yt State of Maryland / Department of Health and Mental Hygiene 2 0 | 2

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	dical niner	4a. Facility Name (if not institution, giv	re street and number)		4b. City, Town, or	Location of Death		4c. County		
/		Cherrywood Nu				terstown		Ba	1tim	
Fune: Direct	_		Sex 7. Age (Ir 1 □ M X [X]F	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Country	ace (State or Foreign v)
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	2		building, etc. (\$	эреспу)			City or Town,	, State)		
Hospi 24 hou Funer tely fil	Medical	(Check 2 Medical Exam	nysician: To the best of my miner: On the basis of exar	mination and/or inves	tigation, in my opini	on, death occurred	at the time, date and	d place, and due	e to the caus	se(s) and manner stated.
o the	Σ	only one) 3 La Certifying Nu 29b. Signature and title of certifier	urse Practitioner: To the b	est of my knowledge	29c. Licens	e number	25	9d. Date signed	(Month, D	ay, Year)
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シャ		30. Name and address of parson who Kninussian C. Sha		th (Item 23a) (Type, F	Pos Print) Q	8852	11-1	DONS	181	9 2012

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ooris E. Levin 10 2012 10:30 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Numbe 7. Age (In vrs. last birthday) 8. Oate of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Min 109-09-0450 Director 1 M 2 D F New York 8-12-1915 Usual Residence of Deceden 10b. County with the Maryland 10a. State ms 23a or 28a-f aho 10c. City, Town or Location 10d. Inside City Limits Direct MO Montgomery Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera United States 9707 Old Georgetown Road 20814 Page 1 and 2 should be filed within 72 hours after death ment of Health end Mentel Hygiene. It is marked other then "natural", or items ury or other traumatic event, the Medical Examiner or 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Veterans Administration Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unknown) Jake Frankel Lina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2520, Cherry Hill, New Jersey, 08034 Fred Levin - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or ot Date 20c. Location - City or Town, State 1 DxBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden Of Remembrance 10-28-2012 Clarksburg, Maryland Signature of Funeral Service Licensee Edward Sagel 22. Name and Address of Facility Edward Sagel Funeral Oirection 2 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Clostridium Oifficile Colitis disease or condition Medical resulting in death) Oue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami are has been signed by the attending physiclen and page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy Hospital or Attending Physician: The 24 hours after death.
 Funerel Director. After this certificate is letely filled in by the funeral director, pag Yes 2 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Liles Division 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/ 66264 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak Pirouz - 8600 Old Georgetown Road, Bethesda, Maryland 20814

DHMH 17 Rev 06-2011

State Registrar

10/25/2012

Doris

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34809 State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 6:45 ам Jacob Charles Lish 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Potomac Potomac If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 578-40-6358 1 X M 2 □ F Director Yrs 92 March 02, 1920 New York Usual Residence of Decedent r than "natural", or items 23s or 28e-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Gaithersburg 1 ☐ Yes 2 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 20878 U.S.A. 23 Arch Place. #376 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Di Yes 2 Di No Navy Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 hours efter 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Hygiene. other than "natural", White Completed 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mentel H is marked of Ida Scop Abraham Lish .. Pege 1 end 2 should be tment of Heelth end Men tant: If Itam 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 745 Chestertown Street, Gaithersburg, Maryland 20878 Samuel Lish - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1 Depertment of h Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State Judean Mem. Gardens 10/28/2012 Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner <u>Dysphagia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hoepitel or Attending Physicien: The lew requirss that the deeth certificate be executed thin 24 hours efter deeth.

The Funarei Director: After this certificate hes been signed by the ettanding physicien end mpletely filled in by the funerel director, page 2 should be deteched for use as the buriel-trensit ettanding physicien end for use es tha buriel-trensit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure To Thrive 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hoep within 24 hou To the Funal completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35791 October 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, Suite 227, Silver Spring, Maryland 20902 M.D. Merlyn Vemury, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2:03AM 201 vdenic Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederic STOW Choice 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year Funeral Min. 1 2 M 2 🗆 F 010 Massachusetts 334-18-64 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 10d, Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Frederick Adamstown MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21710 Funeral 3200 Baker Circle #A-109 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1X Yes þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white Completed 3

Widowed 4 □ Divorced 41-46 Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 commerical banker financial Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Edna Stewart Frederic L Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Hummingbird Crt Ijamsville MD Philip D. Lee/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Sther (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final Physician/ cment Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in modiate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Dav in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the aid be detached to Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe has death? 2 No Yes 2 5 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: **X** Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signati 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21702

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

12-08000 Robert Lesueur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 348 | | State of Maryland / Department of Health and Mental Hygiene

	F	- For State Registrar	Certific	cate of Death		Reg.	No.	
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Robert Maurice Lesueur				October 22,		3. Time of Death 1100 hrs
		4a. Facility Name (if not institution, give street and Prince George's Hospital Center	number)	4b. City, Towr	n, or Location of Death	1	4c. County of Deat Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 1 1 M 2	7. Age (In yrs. last bi		Year If Under 24Hrs Days Hours Mir	_	(MM/DD/YYYY) 9. Bi Forei 7 13, 1989 Cd	an
ore, MD 21215-0036 s. I and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23 her traumatic event, the Medical Examiner must be no	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State	10c. City, Town Washing t 103 Decedent Ever in U.S. d Forces? s 2 X No Year grade completed) 16a e (1-4 or 5+) 11 12 15 16 17 17 18 18 18 19 19 10c. City, Town Washing	n or Location gton 10f. Zip Cor 2000	of Hispanic Origin? (Suban, Mexican, Puerto No specify: cupation (Give kind of glife. DO NOT use ret 18.Mother's Name Althea L Street and Number or ceet NE, Apt. of cemetery.	pecify Yes or No-Rican, etc.) work done fried) a (First, Middle, Maesueur Rural Route Numbr	. Citizen of What Cou US 14. Race - Amer White, etc. Specify: B] 6b. Kind of Business Groundkeepi iden Surname) er, City or Town, State ington, DC 20 20c. Location - City of	10d. Inside City Limits 1 X Yes 2 No Intry? Idean Indian, Black, ACK Industry Ing 9, Zip Code)
Physician Import	1	21 Annature of Fund the vice Licensee 23a. Part / Enter the disease, or complications the failure. List only one cause on each line.	Class	22. Name and Add	dress of Facility	dar Hill Fi	meral Home,	
executed band an and an transit a	Exam	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a bull to conditions).	is a consequence of): is a consequence of): is a consequence of):					-
. Box 68760, he death certificate be y the attending physici hed for use as the buri	by Physician/I	13b. Was decedent pregnant in the past 12 months?	es, outcome of pregnancy re birth egnant at time of death aknown	2 Fetal death 5 Other (Specify)		23e. Did toba	acco use contribute to	Day Year
of Vital Records, P.O ag Physician: The law requires that ther this certificate has been signed be neral director, page 2 should be detact	ŏ,	25. Was case referred to medical examiner? Hospital:	Inpatient 2 ✓ ER/I		Place of Death (Check		prior to death?	
- = ^ 4	Certification: To	1 Natural 5 Pending Investigation 2 Accident 28e. P	ate of Injury 28b	o. Time of Injury 28c. 50 hrs 1	Injury at Work? Yes 2 ✔ No	28d. Describe ho Subject shot	w injury occurred	ural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		3 Suicide Could not be	best of my knowledge, do	Home leath occurred at the tim	ne, date and place, an	due to the cause(ted.
	Medical	and manne 29b. Signature and title of certifier August 196 30. Name and address of person who completed of	er stated.	29c, Li	cense number		29d. Date signed (Mo	onth, Day, Year)
Ju		Laron Locke MD Assistant Med	ical Examiner 90		treet, Baltimore,	MD 21223		
Sta Regist	ate rar	31. Date filed (Monto or 0 ar 2012 32	Registrar's Signature	parte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year Month 5:26A M 30 June Lautz 2012 Rita 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Good Samaritan Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Days Hours Min (Month, Day, Year) **Director** 219-26-1203 1 M 2 K F 75 09/23/1937 Maryland Usual Residence of Deceder 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 301 Trimble Road, U.S.A. Apt. A-1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. \$ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. 1 Yes 2 No Specify. Specify: Asian American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Psych Clinical Specialist Medical 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emilio Carlos Malimit Ruth Harper MacDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Health er Importent: If Item 27 is eny injury or other treu Patrick Peters / Son 405 Lakeview Avenue, Edgewater, MD 21037 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 11/01/2012 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician CA-D disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Disc to (or as a nonsequence of Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last physiclan Physician/Medical Rt O Division of Vital Records, P.O. Box 68760 as the attending p IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cate hes been sig , page 2 should to 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ٩ 1 Npatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred After t To the Hospital or Attending 5 \square Pending **V** Natural within 24 hours after death.

To the Funere! Director: Af
completely filled in by the fu 1 Yes 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D73321 AMAL ASHEAF, MD

State Registrar

5601 Loch Raven Blvd., Baltimore, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signatu

Amal Ashraf M.D.

31. Date filed (Month, Day, Year)

NOV 0 1 2012

10-30-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year ΡМ <u>Gerard Joseph Lauer, Jr</u> 5:40 October 30. 2012 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 5304 Harford Road Apt. B301 N/A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 217-40-9464 1**XX**M 2 □ F 69 01-12-1943 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A 1 ves 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5304 Harford Road Apt. B301 21214 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Vietnam Year or Dates. 1 Never Married 2 Married 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Retail Sales 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Surname) Estelle Victoria Lutz Gerard Joseph Lauer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miss Amy Lauer - Daughter 4309 Arabia Avenue Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) emetery, crematory or other place, Hilltop Service Corp. 11-01-2012 Towson, Maryland of Euneral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Caus (Final disease or con in ion Onset and Death SEPSIS resulting in death) Due to (or as a consequence of): INFECTION RIGHT LOWER EXTREMITY DAYS Sequentially list conditions. many, leading to immediate cause. Enter Underlying Cause (Disease or injury 1SCHEMIA FOUT CRITICAL that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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Inked other than "natural", or items 23a or 28

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permit. Page 1 a
Department of H
Important: If ite
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Director

Funeral

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Completed

Be

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the Maryland

Baltimore, Maryland 21215-0036

Examine burial-tra by Physician/Medical the ed by t detach Completed Be ျ filled in by the funeral Certificate: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Medical

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

	PERPHER	AL VASCUE	AR DISEASE	5	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🔲 Ectop	oic pregnancy (specify)	//A	23d. Date of delivery Month Day Year
Part II. Other significant conditions con	LITUS	,	ng cause given in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
CORNART AN	estry pises	<i>बर्ड</i>		per	ss an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)	
1 Yes 2 No	ospital: 1	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Re	sidence 6 Other (Specify)
27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury at	28d. Describe	how injury occurred
Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	N/A	injury M	work? 1 🗌 Yes 2 🗌 No	N	(/A
4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		tory, office		(Street and Number or Rural Route Number, own, State)
(Check 2 L Medical Examine	er: On the basis of examinatio	n and/or investigation,	in my opinion, death occurred	at the time, date	cause(s) and manner as stated. e and place, and due to the cause(s) and manner stated. o the cause(s) and manner as stated.
29b. Signature and title of certifier			29c. License number		29d. Date signed (Month, Day, Year)

D 26521

State Registrar 31. Date filed (Month, Day, Year)

NOV 0

MARGARET EBY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8, per fn, g933 11-5-12 sm

State of Maryland / Department of Health and Mental Hygiene
Amend #7 per UVR G935 1/16/13 dk

Certificate of Death

Reg. No. 2 | | 2 For State Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Oct. Physician/ 2012 08:00A M Grace Esther Ludwig Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carrol1 3691 Maple Grove Road Manchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 87 90 Director 219-14-1993 1 M 2XXF Vrs Aptil 22. Maryland Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director MD Manchester Carrol1 1 Ves 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral USA 21102 3691 Maple Grove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural" 3€XWidowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Wood Flooring Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Rose Hierstetter Clarence Cullum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3012 Delaware Avenue Baltimore, MD_21227 Susan Arata / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park Nov. 2,2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signature of Fune al Service Lie 1328 Sulphur Spring Road Arbutus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ Bleedin Acute UGI disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Sever Aremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and the burial-trar resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown signed by the atter Month Day Year 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performe 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes _2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending after death, eral Director: A filled in by the f Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge that noccurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Wiedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 137940 ted cause of death (tem 23a) (Type, Print) 21157 30. Name and address of et here Sut 201 westwonster MUS ~ Boerlase W. State 2012 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#17perFH, G933,11/27/2012, WS
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#17,18,20b, perFH, G933,11/29/2012, WS
Certificate of Death

Reg. No. 12 - State Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Oct 25, 2012 9:30 A Mary Margaret Mason /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Kris Leigh Assisted Living Gambrills If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Director 92 Oct 3, 1920 090-18-7735 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 ie marked other than "naturei", or items 23a or 28a-f ehow other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director MD Anne Arundel Odenton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death Funerai USA 828 Sunny Chapel Rd 21113 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 ie marked other than "naturel", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify. ģ 3 ₩Widowed 4 □ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) **Holloren** 17. Father's Name (First, Middle, Last) Be Burns Kane Michael Byrne Bessie Helloren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Kane 828 Sunny Chapel Rd., Odenton, MD 21113 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 tment of P rtant: If it 1XX Burial 2 Cremation 3 Removal from State ŏ Nov. 2, 2012 permit. Page Depertment of Important: If eny injury or once. Holy Road Cemetery Westbury, NY 4 □ Donation 5 □ Other (Specify) 21. Sign wife of Funeral Service License 22. Name and Address of Facility Gregory Fink Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or shock, otheart failure. Stroke Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Jordyng Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ó in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknowe 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 1 Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 When (Specify) Hospital: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a cai 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature appointed of certifier 29c. License number 10/26/12 MD ess of person who completed cause of death (Item 23a) (Type, Print) Windswept ct. Folkton ma 21047

State Registrar Jude Muneses MD

back

2305

2. Registrar's Signature

MILLER, VERNON

		Please	Type or Print in	Black II	ndelible Ink	k. Ensure	All Copie	s Are Leg	jible.	
		For State	State of Maryla				Mental Hy	giene	10	21.216
		Registrar 1. Decedent's Name (First, Middle, Last		Cei	rtificate of D	Death		Reg. No. 4	14	34010
Physicia			*	LER,	TR.		2. Date of De	Day	Year	3. Time of Death 5:2/ P.M.
Medio Examir		4a. Facility Name (if not institution, give :			4b. City, Town, or	Location of Death		4c. County	of Death	J. all /
		FRANKLIN SQU.	ARE HOSPIT	TAL	0	SEDALE				IDRE
Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl	h		place (State or Foreign
Director		Usual Residence of Decedent	X M 2 □ F	82 _{Yrs.}			8-4-1			RYLAND
and show	힏	10a. State 10b. County		ity, Town or Lo					1	0d. Inside City Limits
Mary 28a-f otifie	Director	MD BALT	IMORE		ROS	EDALE				1 Tes 2 No
th the 3a or t be n		10e. Street and Number 8343 ANALEE AVI	TMITE		10f. Zip Code	21237		10g. Citizen of	What Cour	
ath wi	Funeral	11. Marital Status	12. Was Decedent Ever in U	C 112.1	Was Decedent of His		posify Vos or No-			
6 er de or ite miner	by F	1 Never Married 2X Married	Armed Forces?	'	f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Blac	e - Americ ck, White, e	etc.
JOS urs aft ural",	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates. 194	8	1 ☐ Yes 2 🔀 No	Specify:		Specify	WHI	TE
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illed w Il Hygi Vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan				
ylar Id be	욘	VERNON LEROY	MILLER,	SR.		CATHER	INE	KE	RNEF	{
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	9	19a. Informant's Name/Relationship (Typ DOROTHY K. MILLI		19b. Mailir	ng Address (Street a	nd Number or Rui	ral Route Numbe	r, City or Town, S EDALE,	State, Zip C	^{Code)} 21237
and 2 and 2 Health tem 2		20a. Method of Disposition			sition (Name of	; AVENOI	Date	20c. Location		
nor age 1 ent of the life if if		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, cren	natory or other place	1			•	
altii mit. P partm portar y injur se.		21. Signature of Funeral Service License		RKWOOI 22	CEMETE 2. Name and Addres	s of Facility	2-2012 ACH/ROS	PARKV	TTTT	ERAL HOME
Bal permi Depar Impo any ir		20		一 1:	211 CHES	ACO AVI	ROS	EDALE,	MD	21237
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Medical Examiner		resulting in death)								
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Box 68760 death certificate b the attending physined for use as the t	iciai	in the past 12 months?	1 Live Birth 2 Fei		Ectopic pregnancy Other (specify)	/		1		Day Year
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of ng Ph ffer th Ineral		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		at		ow injury occurr		
Division of Vital Records, lal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be a line by the funeral director, page 2.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆 `	Yes 2 No				
IVIS lor At after a Direc	Cer	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specit		et, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
Spita spita hours meral y fillec	Medical	29a. Certifier Certifying Physi	cian: To the best of my knov	vledge, death o	occurred at the time,	, date and place, a	and due to the ca	use(s) and manr	ner as state	ed.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Med	(Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of examination Practitioner: To the best of	on and/or invest	tigation, in my opinior	n, death occurred a	at the time, date a	nd place, and du	e to the cau	use(s) and manner stated.
To t To t		29b. Signature and title of certifier	Fl. use		29c. License			29d. Date signer		
		D. Pajsulu	/			5000	0	10-	C 4-	2012
9+1		30. Name and address of person who co	ompleted cause of death (Iter Redd 1 md	n 23a) (Type, P	FRANKI	in Sai.	A DO	BOIL	n Wa	1 21737
Stat	_	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	ature	a. N.	440	C 1 6- V	10000		21237
Registra	ır	NOV 0 1 20	172 Server	p. 19.	and the second					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Glenda McCullough 2012 3481 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 24, 2012 Medical Examiner 1404 hrs Glenda McCullough 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 404 Meidan Valley Circle Reisterstown **Baltimore County** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign £1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Months Days Hours Director Country Salvadore 217-11-8942 1 M 2XXF 36 Jan. 17, 1976 Usual Residence of Decedent 10d, Inside City Limits 10c, City, Town or Location 1 Yes 2XXNo 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Baltimore Reisterstown Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 404 Valley Meadow Cir., Apt. A2 U.S.A. 21136 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 XXMarried 2 XX No Yes White If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 11th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Unknown Marta Lopel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type, Print) timore, MD Anthony McCullough (Husband) 404 Valley Meadow Cir., Apt. A2, Reisterstown, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date All Faiths Crematory 1 Burial 2 XXCremation 3 Removal from State 11/2/12 Manchester, MD Donation 5 Other Specify: Chapel 11/2/12 | manches of Facility Eckhardt Funeral Chapel, P.A. Signature of Fundam Solvice Licensee 11605 Reisterstown Rd., Owings Mills, MD 21117 Pat J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near the mode of dying, such as cardiac or respiratory arrest, shock, or near there. List only one cause on each line. Combined drug (Sertraline, Lamotrigine, Quetiapine) Approximate Interval **Physician** Between Onset and /Modical aIntoxication Death Immidiate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Dun to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical 9 per fh g933 ll-1-12 ,28a-f,per me,g934 l2-1 X UNPENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 2 should l 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' 1 🗸 Yes ✓ Yes 2 No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene After this 1 Yes 2 No 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: Natural Director: 1 Yes 2 X No 5 Pending fd 10-24-12 fd 1:46 pm within 24 hours after dea

To the Funeral Director
completely filled in by th Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 404 Meidn Valley Cir. Reisterstown, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be (Specify) Residence determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OGME October 26, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD.

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

NOV O

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26, 2012 Karl Francis Maevers Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death SAINT JOSEPH TOWSON MEDICAL Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Davs Min (Month, Day, Year) Director 213-30-4451 **X**XM 2 □ F 81 April 25,1931 Maryland show in then "naturel", or items 23e or 28e-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Baltimore G1yndon 1 🗌 Yes 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4615 Prospect Ave. 21136 U.S.A 12. Was Decedent Ever in U.S.
Armed Forces?
XIX Yes 2 □ No
If Yes, Give
Year or Dates. Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. δ 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hyglene. Is merked other then Elementary/Secondary (0-12) College (1-4 or 5+) Banker Banking Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Karl Herman Maevers Dorothy Nesbit Reader Pege 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if it of Heelth a Marie C. Maevers / Wife 4615 Prospect Ave. Glyndon, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Depertment of himportent: if its any injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/2/12 Manchester, MD 4 Donation Other (Specify) ery & Chapel: 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Juneral Supple Licenses 11605 Reisterstown Rd. Owings Mills, MD 2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition and the cause of t Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ettending physicien end I for use es the burial-transit or Attending Physicien: The lew requires thet the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death To the Hospital or Attending Physiclen: The lew requires thet the des within 24 hours after deeth.

To the Funerel Director: After this certificete hes been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မြ 1 Dinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the urne, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ p M Libby Bernstein Mandell 10 2012 6:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery #106 Chevy Chase 5600 Wisconsin Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 579-88-1724 **Director** 1 □ M 2 🖄 F New York 12-2-1912 Usual Residence of Decedent fshow 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at death with the Maryland Director Chevy Chase 1 X Yes 2 No Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funera United States 20815 #106 5600 Wisconsin Avenue. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 Married þ hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Philanthropist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lena Spiro Emanuel Bernstein permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1012 West Upsal Street, Philadelphia, Pennsylvania 19119 Judy Elson - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-31-2012 Falls Church, Virginia King David Mem. Gardens 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Edward Sagel 22. Name and Address of Facility Oanzansky Goldberg Memorial Chapels auc 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia Medical resulting in death) Due to (or as a consequence of): [′]Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the hurtal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) 1 🗌 Yes 2 ☐ No ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number 10-24-2012 050030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)



David Rogers, MO - 5530 Wisconsin Avenue, #1400, Chevy Chase, Maryland 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2012 7:45 pm William Bradford Matthews Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner #613 Silver Spring Montgomery 3112 Gracefield Road, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Months Hours 072-22-1976 Director 1 🗶 M 2 🗆 F 85 01/29/1927 New York Usual Residence of Decedent and war it all Highen.
I is marked other than "ratural", or items 23e or 28a-f show mannate event, the Modes Exeminer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Silver Spring Maryland Montgomery 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral U.S.A. 20904 3112 Gracefield Road, #613 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Korea White 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within Hospitality Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olive Beulah Richardson George Tennyson Matthews .. Pege 1 and 2 should b tment of Health and Mer tent: If item 27 is mark jury or other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 3112 Gracefield Rd. #613, Silver Spring, MD 20904 Enriqueta Pretzer Matthews/ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Pege 1 a Department of H Importent: If ite eny Injury or ot 1 X Burial 2 Cremation 3 X Removal from State 11/03/2012 Brooklyn, New York Green Wood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M00707 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death
Years Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and compietely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Multiple Myeloma 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) B B Other: 4 \sum Nursing Home 5 \textbf{X} Residence 6 \sum Other (Specify) 1 🗌 Yes 2 🛛 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 57284 31 2012 UCT

Registrar
DHMH 17 Rev 06-2011

State

3110 Gracefield Road, Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

€32. Registrar's Signature

M.D.,

Anna Korzan,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4-50 TM 20 Physician/ Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death HVERUE . Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Director 1 🗆 M 2 🖫 F Carolina th. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "netural", or Items 23e or 28e-1 show ury or other treumatic event, the Medical Evanties must be notified at 10b. County 10a. State **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No altimore 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\mathcal{A}123\%$ atons Dona 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MD 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END-Stage Dementiq disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Territoring Nurse Prantition or T. the basis of my knowledge death occurred at the time, date and place and due to the cause (s) and manner stated a Territoring Nurse Prantition or T. the basis of my knowledge death occurred at the time, date and place and due to the cause (s) and manner stated 29b. Signature and title of certifie 29c. License number n SRajapanemo 0057465 10/26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba I Hmore NSKajapaKseMo 5832 S 203 SMITH AV MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOA 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34822 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HEHRY HORRIS 10 2015 WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE VA MED CENT BALTIMOR 3 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) Director 220-14-2485
Usual Residence of Decedent 1 X M 2 D F 02 87 SC 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Evaniner must be notified at Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2835 West Garrison Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working ye 1 and 2 should be filed within 7/ t of Health and Mentel Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Self Employed 6th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Herbert Norris Flora Niae Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lizea Norris-Wife</u> <u> 2835 West Garrison</u> Md 21215 Ave Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite eny injury or ot once. Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/2/2012 Owings Mills, Md rison Forest 21. Signature of Funeral Service Licensee March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart adjure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 300 Wabash Ave, Baltimore, Md Onset and Death Physician/ Medical bue to (or as a consequence of): Examiner EXACERBATION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a nonsequence off • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and eleipy filled in by the funeral director, page 2 should be detached for use as the burlansit eleipy filled in by the subrear director, page 2 should be detached for use as the burlansit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No or Vita 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 욘 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 M. GREENE ST. BALTMORE MD JACQUELIME 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

NOV 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2614 McKinney Esther Mae 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospita Baltimore If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Director 1 🗆 M 2 🔀 F 87 2-20-2453 25 04 12 MD Usual Residence of Deceden 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No MD NA Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23a** Funeral U.S.A. 21215 4203 West Rogers 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. <u>-</u> þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. osewood State Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade Nurses Assistant Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Contee Sara Contee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21215 Glenda McKinney-Daughter 4203 West Rogers Ave, or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Aonation 5 ☐ Other (Specify) King Memorial Park 11/2/2012 Woodlawn, 22. Name and Address of Facility March F/H West 4300 Wabash Av 21. Signal Euneral Service Licensee Baltimore, ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) nset and Death Epilepticu Physician/ Medical Due to (or as a consequence of): Examiner vascula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diobetes 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension performed? Yes 2 X No siezwe disorder 1 ☐ Yes 2 XNo 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) (Specify) 1 Yes 2 X No Certificate: To 1 Malinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature/and title of certifier 26th)ctober, 2012 30. Name and address of person who cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State of Marylan	•				0.0	112 34824
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eatn	2. Date of Deat	eg. No. <u></u>	201 2 3. Time of Peath
	Physicia Medic	al	Marion D. Meeks				00	28	2012 10:48 M
District Control	Examin	er	4a. Facility Name (if not institution, give street and number) 905 Langley Road		4b. City, Town, or t				y of Death
Section 200	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday,	If Under 1 Year	Burnie If Under 24 Hrs. Hours Min.	8. Date of Birth		ne Arundel 9. Birthplace (State or Foreign
	Director		220-16-7158 1 □ M 2X F 8	7 Yrs.	Months Days	Hours Min.	Jan. 10		Country) MiD
	show dat	ō	10a. State 10b. County 10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
	e Mary 28a-f	irec	Maryland Anne Arundel			Burnie			1 ☐ Yes 2 🔀 No
	vith the 23a or st be r	Funeral Director	10e. Street and Number 905 Langley Road		10f. Zip Code	21060	1	0g. Citizen of	What Country? USA
	items		11. Manital Status 12. Was Decedent Ever in U.: Armed Forces?	S. 13. V	Vas Decedent of His f Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No- Rican, etc.)		ce - American Indian,
36	after or samir	d by	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates.		☐ Yes 2 🔯 No			Specify	
2-0	hours "natur dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done du	tion	ina	16b. Kind of E	Business/Industry
Maryland 21215-0036	ithin 7% ene. • than the Me	E C	Elementary/Secondary (0-12) College (1-4 or 5+)		0 NOT use retired) Manager	3			мта
מפ	filed w al Hygi I other vent, I	Be	17. Father's Name (First, Middle, Last)	1		18. Mother's Nam	e (First, Middle, N	laiden Surnam	
ylaı	uld be I Ment narker natic e	욘	Charles F. Davis			Vera	Bell	Haswel	
Ma	12 sho alth and 27 is r r traur		19a. Informant's Name/Relationship (Type, Print) Charles W. Meeks Jr. (son)		ng Address (Street ar Langley F				1
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1	Place of Dispo	sition (Name of natory or other place		Date		- City or Town, State
ţi	it. Pago rtment rtant: I		4 ☐ Donation 5 ☐ Other (Specify) HO.		ll Memoria	ıl Gar. 2	2012	Baltim	nore, Maryland
Ba	Depa Impo any I		21. Signature of Funeral Service Licens	2		intain Ro	ad, Pasa	idena,	eral Home, P.A. MD 21122
			23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.)		, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
, in the	Pnysician/ , Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a Lonseq	uence of):	ma				
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	cate be executed physician and s the burial-transit	edical Examine	that initiated events ' c. Due to (or as a consequence of the consequence)	quence of):					
9	ate be ohysicia the bu	dica	d						
687	death certificate be executed he attending physician and led for use as the burial-trans		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 □ Live Birth 2 □ Fet		☐ Ectopic pregnancy			23d. D	Date of delivery
P.O. Box 687	death the atte	Physician/M	in the past 12 months? 1 \rightarrow es 2 \rightarrow No 4 \rightarrow Pregnant at time of 9 \rightarrow Unknown 9 \rightarrow Unknown		Other (specify)			N	Month Day Year
P.O.	Attending Physician: The law requires that the redath. sector: After this certificate has been signed by the funeral director, page 2 should be detech	by Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to the cause of death?
	quires en sigr	ted b					1 □ Y		3 Probably 4 ☐ Unknown
SO	has be ge 2 sh	Completed					24a. Was a autop perfor	sy	b. Were autopsy findings available prior to completion of cause of death?
E E	an: The tificate tor, pa	Be Co	25. Was case referred to Medical		26. Pla	ace of Death (Chec		2 No	1 Yes 2 No
Z:	hysici his cer al direc	은	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2			4 ☐ Nursing H	ome 5 N Resid		
n of	ding P th. After t funera	cate:	27. Manny of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28b, Time of injury	work'	at ? Yes 2 □ No	28d. Describe h	ow injury occu	rred
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be deteched for use as	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At h building, etc. (Specif		reet, factory, office		28f. Location (S City or Tow		ber or Rural Route Number,
Δ	Hospital of 24 hours at Funeral D		29a. Certifier 1 Certifying Physician: To the best of my know	wledge, death	occurred at the time	, date and place, a	and due to the ca	use(s) and ma	nner as stated.
	the Ho hin 24 I the Fu	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of	on and/or inves fmy knowledge	e, death occurred at the	ne time, date and p	lace, and due to the	ne cause(s) and	d manner as stated.
	Neith o		29b. Signature and title of certifier	n	29c. License	/ SS	72	Date sign	ned (Month, Day, Year)
	0 /		30. Name and address of person who completed cause of death (Itel	m 23a) (Type, I	Print)	Al	1/	1 1	7 2111
	√ Sta	te.	31. Date filed (Month, Day, Year) NOV U 1 2012	nature	1/4 X'C	510	11 00	n Di	(RUND TOD)
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Stin	gar					

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ohn William Mos			ment of i licate of i		tal Hygier		2012	34825				
Physician		Registrar 1. Decedent's Name (First, Middle,Last)				Reg. e of Death		3. Time of Death				
Medical Examine	er	John William Mosch		Oit. Tour or Leasting		ober 27,	2012 4c. County of Death	0810 hrs				
		4a. Facility Name (if not institution, give street and number) Beaver Dam Rd at Chelan Rd	40	c. City, Town, or Location of Cockeysville	or Death		Baltimore Coul	nty				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	birthday) Yrs.	If Under 1 Year If Under Months Days Hours		ate of Birth(MM/DD/YYYY) 9. Birti Foreigr 1954 Cou	nplace (State or intry) D.C.				
'n		Usual Residence of Decedent 10a, State 10b, County 10c, City, Tov	wn or Locatio	in .				10d, Inside City Limits				
d how any	-	MD		Baltin	nore			1 Yes 2 No				
11215-0036 Id be filed within 72 hours after death with the Maryland femial Hygiene. narked other than "natural", or items 23a or 28s-f show ever, the Medical Examiner must be notified at once.	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Coun					
ith the 3		700 Hollen Road 11. Marital Status I 12. Was Decedent Ever in U.S.	13 \//26	212 Decedent of Hispanic Original		es or No-	US 14. Race - Americ					
items	a	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		s, specify Cuban, Mexican,			White, etc.					
after d	로 참 -	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 No specify:			Specify.	White				
hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		s Usual Occupation (Give l st of working life. DO NOT		ne 1	6b. Kind of Business/Ir	-				
036 thin 72 ne. than ledical	Completed	12 4		Artist				nployed				
MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 a 27 is marked other than native conet, the Medica		17. Father's Name (First, Middle, Last) Albert Moschetto		18.Mother	's Name (First,		iden Surname) ma Meyers					
21215 buld be file Mental H marked ic event, t	99		19b. Mailing	Address (Street and Num	nber or Rural R			Zip Code)				
and 2 should tealth and Me tem 27 is ma traumatic er	-1	Meg Zimmerman / Wife		Iollen Road, Balti			On Landin City	Taura State				
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If iten 27 is ma injury or other traumatic error		1 Burial 2 Cremation 3 Removal from State cren	natory or othe		Date		20c. Location - City or					
Baltimore, permit. Pages 1 a Department of He Important: If ite	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		e Crematory	10/30/20	012	Beltsvi	ile, MD				
Ba Perm Depa Impo	-	21. Signature of Funeral Service Licensee Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore										
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the	e mode of dying, such as c	ardiac or respi	ratory arres	t, shock, or heart	Approximate Interval Between Onset and Death				
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23c. If yes, outcome of pregnant 23b. Was decedent pregnant in the	[al death 3 Ectopi	c pregnancy		23d. Date of delivery) Day Year				
x 68 h certif tending use as	ician I	past 12 months? 4 Pregnant at time of death	=	al death 3Ectopi er (Specify)	c pregnancy		I World	,,,,				
BO he deat y the at hed for	yu's	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause given in Pa	art I. 2	3e. Did tob	acco use contribute to	the cause of death?				
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge.	death occurr	red at the time, date and pl	ace, and due to	o the cause	(s) and manner as stat	ed.				
To the Hos within 24 h To the Fur	Medical	one) 2 ✓ Medical Examiner: On the basis of examination and/	or investigati	ion, in my opinion, death o	ccurred at the t	ime, date a	nd place, and due to th	e cause(s)				
FSFO	ž	29b. Signature and title of certifier		29c. License number O.C.M.E.			29d. Date signed (Mo October 28, 201)					
		30. Name and address of person who completed cause of death (Item 23		J.J.IVI.L.			- 5,550, 20, 201					
		Patricia Aronica-Pollak MD. Assistant Medical Ex	aminer	900 W. Baltimore St	treet, Baltin	nore, MD	21223					
Sta Registr		31. Dat 104 April Day (1942) Signatura 32 Registrati Signatura	ala					9				
Vealer	31.											

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 28 Physician/ 2012 730 PM October Arlene Eugenia Mason Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Meritus Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Social Security Number If Under 8. Date of Birth **Funeral** Days Months Hours Min (Month, Day, Year) 121-32-2241 Director 1 M 2 X F 01/29/1942 70 New York Usual Residence of Decedent 28a-f show 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No San Bernardino San Bernardino CA 10e Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 23a 92404 U.S.A. items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed Black Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ລe filed wha. ∸al Hygiene. ົຈr than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Psychiatric Aid Medical permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important. If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugenia Stenhouse Ann Elgie Dockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) East 17th St., #37, San Bernardino, CA 92404 222 Terrance Dockett / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11/01/2012 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry Service Licerise 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TYYPS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ovascular Disease hertensive cuertially list our ditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NYOME the burial-tran attending physician and Due to (or as a consequence of) Physician/Medical oar use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed? Yes 2 No has 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tyes 2 🔀 No P 1 🗌 Inpatient 2 🖰 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury Natural 5 Pendina work?
1 Yes 2 No

P.O. Box 68760 Hospital or Attending Physician; The law requires that the Records, 24 hours after death.

Funeral Director: After this certificate I Division of Vital completely filled in by the funeral director, Certificate: Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 the only one) within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

Registrar

31. Date filed (Month, Day, Year) NOV 0 1 2012

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2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Year oct 30 Physician/ Loretta Ellen Miller 8:25 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Westminster Sunflower Hill Assisted Living Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** (Month, Dav. Year. 212-34-7605 1 □ M 2**X** F 76 Director 9-13-1936 MD Usual Residence of Decedent 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Westminster 1 Yes 2 No Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 Funeral 410 Baldwin Park Dr., Apt T1 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Black, White, etc. Armed Forces?
1 ☐ Yes 2 🕱 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specifywhite Completed 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred E. Sauter ည Edward V. Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 101 Trevanion Rd., Taneytown, MD 21787 Francis E. Miller-son f Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1
Department of I
Important: If its
any injury or of 1 Removal from State Good Shepherd Cem 11/2/2012 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) usclarati Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last is certificate has been signed by the attending physician a director, page 2 should be detached for use as the burialby Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to a hours after cleath.
• Funeral Director: After this certificate has been signed by the attending physicial letely filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Vear Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) A Sh Maller ing 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 D Suicide 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hospi within 24 hou To the Funer completely fil ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO018200 10-31-12 GazishanKAR Poole Kd 31. Date filed (Month, Day, Year) State NOV 0 1 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Joseph Charles Matthews	State of Maryland / Department of Health and Mental Hygiene		20	0	0100
1- For State Registrar	Certificate of Death	Reg. No.	201	4	3482

		Registrar Certificate C	of Death		F	Reg. No.	COIL	0402
Physicia		Decedent's Name (First, Middle,Last)	-		2. Date of De		Year	B. Time of Death
ledical Exami	ner	Joseph Charles Matthews			October	Day 27, 2012	I trail	1135 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or L	Location of De			ounty of Death	
		772 Cypress Road	Severna Par	rk		Ann	e Arundel	
Funcion		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24	irs. 8 Date of B	Birth (MM/DD)	YYYY) 9. Birth	place (State or
Funeral Director		217 46 3124	Months Days	+			94 ^{Foreign}	
Director		$217-46-3124$ $1 \times M$ $2 - F$ 65 Yr			Marc	11177	Cour	itry) 112
		Usual Residence of Decedent						
#Dy		10a. State 10b. County 10c. City, Town or Local						Od. Inside City Limits
P P	_	MD Anne Arundel Se	verna P	ark				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	왕	10e, Street and Number	10f, Zip Code			10g. Citizen	of What Countr	y?
Ma rr 28	Director	772 Cypress Road						
with the Maryland ms 23a nr 28a-f sho be notified at once.			211			USA		
ms 2	erai		as Decedent of Hisp Yes, specify Cuban,			14.	Race - America White, etc.	in Indian, Black,
deati r ite	Fun	1 Never Married 2 Married Armed Forces? If Yes 2 No	roo, aposin, caneri,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			hite
fer if	by F	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No	specify:		Spe	ecify:	
urs a			nt's Usual Occupation			16b. Kind	of Business/Inc	dustry
2 ho	ete		most of working life. Norker	DO NOT use r	etirea)	1	Jnion	
136 thin 72 ne. than	Completed	10th 110h	IWOLKEL				3111011	
5-00 led with Hygiene I other	ē	17. Father's Name (First, Middle, Last)	T ₁	8.Mother's Na	me (First, Middle,	Maiden Sur	name)	
215-0036 be filed within 7 mal Hygiene. rked other than		William R. Matthews			zabeth			
2121	Be		ng Address (Street					Zin Codo)
AD 21215-003 2 should be filed within a and Mental Hygiene. 27 is marked other th	۴		Fairway					
MD id 2 shoulth and m 27 is aumati			<u>-</u>					
F. Hear Fr		20a. Method of Disposition 20b. Place of Disposition crematory or c	sition (Name of cem ther place)	netery,	Date	20c. Loc	ation - City or To	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a nr 28a-f ahr nther traumatie event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal from State Bayview	ther place) Cremate	ory 10	0/31/12	Bal	ltimor	e MD
Tit P		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Name and Address	of Facility 5	300 Mac	7776	. Pal+	o MD
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		Valut Tun much						ex 21221
		23a. Part I. Enter the disease, of control dations that caused the death. Do not enter						Approximate Interval
Physician Wegical		failure. List only one cause on each line.	the mode of dying,	soor as cardia	o or respiratory a	riout, oriout,	of flour.	Between Onset and
Examiner		Immediate Cause (Final disease a. Atherosclerotic Card	1	Death				
- Adminior		or condition resulting in death) Due to (or as a consequence of):						
3,4		Sequentially list conditions, b						
	Examiner	if any, leading to immediate Cause. Enter Underlying Cause Due to (or as a consequence of):						
	Ē	(Disease or injury that initiated				-		
asit ed	Ä	events resulting in death) Last						
cecut and		d.	~022 11 1	/ 12 as				
760, icate be exergible by the burial -	n/Medical	x UNPENDED ☐ AMENDED 23a, 27, pe rme,	8933 11-1	4-12 SI	ш			
Box 68760, death certificate by the attending physic defor use as the bur	Ž	#F FEMALE: 23c. If yes, outcome of pregnancy		_			ate of delivery	
ertifi ding	an	Description of death	etal death 3 L	Ectopic preg	gnancy	Mo	onth Da	y Y ear
leath certific e attending for use as t	Sic	4 Ves 0 Ne 0 Helenous	ther (Specify)		_			
bed for	Physicia	9 Olkiowi			Look Bid			
s, P.O. Be ires that the de signed by the 1 be detached fi		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gi	iven in Part I.				e cause of death?
signe be d	d by				_ ¹∟∣Y	es 2N	o 3 Proba	bly 4 🗹 Unknown
ds equi	Completed				24a. Wa			psy findings available
aw I	횰				perf	opsy formed?	death?	mpletion of cause of
Zete page	팃				1 ✔ Yes	2No	1 🗸 Yes	2 No
tal Records cian: The law requi certificate has been ector, page 2 should	Be	25. Was case referred to medical		of Death (Che	ck only one)			
of Vital Records, graysician: The law require this certificate has been sineral director, page 2 should be	70	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA	Other Nur	sing Home 5	Residence	6 🗸 Other:	Scene
ing Ph After t funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of	Injury 28c. Injury	y at Work?	28d. Describe	how injury	occurred	
Bdin H	Ö	1 X Natural 5 Pending	1 Y	es 2 No				
Sic Atte crtoi by th	g	2 Accident Investigation 28e Place of Injury - At home farm str	eet, factory office hi	uilding, etc	28f. Location	(Street and	Number or Rura	I Route Number, City .
Division tal nr Attendi rs after death. Tal Director: #	Certification:	Suicide Could not be determined (Specify)			or Town,			3, 6,7
spits hours		4 Homicide			T.			
e Ho c Fu etely			urred at the time, dat	te and place, a	and due to the cau	use(s) and m	anner as stated	cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital in Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.			u at tile tille, dat			
	ž	29b. Signature and title of certifier	29c, License	number		29d. Date	e signed (Monti	h, Day, Year)
		Vancol Axudlall soil	O.C.N	Λ.E.		Octobe	er 28, 2012	
		30. Name and address of person who completed cause of death (Item 23a)						
İ			0 W. Baltimore	Street. Ba	ltimore. MD	21223		
		31 Date filed (Month Day Vear) 32 Rightstrar's Signature				•		
Si Regis	ate	NOV 0 1 2012 Annual B.	arked					
Regis	10:11	TOTOL COLC CANON AS A						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER Physician/ Newman 2012 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HIGHWay If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 218-36-**Director** 1 M 2 F MI May 28e-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ams 23e or 28e-f sh r must be notified a 1 Yes 2 No altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married ò 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) I Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Bo 12 treumetic event, Be 17. Father's Name (First, Middle, Last) LINK 18. Mother's Name (First, Middle, Maiden Surname) is merked of မ -ielas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) elly 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Pege 1 1 Surial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. 27/2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Dancreatic Cancer Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): for use es the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physicien: The lew requires that the death certificate be ax within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier ocroses 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N- Charles HARLES 6701 31. Date filed (Month, Day, Year, State 32. Registra s Signa

DHMH 17 Rev 06-2011

Registrar

1 2012

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 2012 Joyceline 02:45 AM Nuzzo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1510 Long Point Road Pasadena Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 31 1938 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-36-6871 Days Director 1 🗆 M 2 🛣 F 74 ?7 is marked other then "natural", or items 23e or 28e-f show traumetic event, the Medical Examiner must be notified at 10b. County 10a. State within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 1510 Long Point Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. Š 1 Never Married 2 Married 1 Yes 2X No 1 ☐ Yes 2 ☐XNo Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Office MAnager Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Robert Leftwich Lilly Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Hook (daughter) 1510 Long Point Road, Pasadena, MD 21122 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 e
Department of H
Importent: If ite
eny injury or ott 31 Metro Crematory or other J Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, 23a. Part . Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line. ith. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physician and for use as the burlal-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): rate has been signed by the ettending physician. page 2 should be detached for use as the bester Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certific.
filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 10. 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 - Other (Specify) Certificate: . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Maryland 21215-0036

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2012 Naibert October 1:35 PM Janice Rochelle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bedford Court Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) Director 484-34-7257 1 M 2 X F 76 05/15/1936 Illinois 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 X Yes 2 ☐ No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? Funeral **23**a 20853 16590 Emory Lane U.S.A. if Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 X Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Antiques Dealer Antiques Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Una Vernette Bacon Clay Ranson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 16590 Emory Lane, Rockville, MD 20853 Zane Naibert / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or Anatomy Gifts Registry 10/30/2012 4 X Donation 5 ☐ Other (Specify) Hanover, Maryland Signature of Funeral Service Licens e 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to minimized accause. Enter Underlying Cause (Disease or injury Examine Day to fur as a cur section of chr. burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ≥ 9 ☐ Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be exect Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director; After this certificate within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is

Registrar

မ

Certificate:

Medical

31. Date filed (Month, Day, Year) NOV 0 1 2012

27. Manner of Death

1 Natural

Accident
Suicide

4 Homicide

29a. Certifier

(Check only one) 29b. Signature and title of certifie

5 Pending

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilla 9801Georgia Annu # 1-17

28a. Date of injury (Month, Day, Year)

32. Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28c. Injury at

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work?
1 Yes 2 No

D0054566

4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0/26

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Norate1 2012 12:35 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 505 Millersville Marc Road Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 220-50-4703 1 XM 2 F Yrs 08/29/1950 62 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 Yes 2 XNo MD Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 Marc Road 21108 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married 夕 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene, Elementary/Secondary (0-12) 12 College (1-4 or 5+) Construction Supervisor Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ pe Gladys Gertrude Dukeman William Noratel other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 21108 Millersville, Maryland 505 Marc Road, Mrs. Linda M. Noratel / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/03/2012 Glen Burnie, Maryland Atlantic Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Providian/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery To the Hospital or Attending Physician: The law requires that the death, within 24 hours after death.

To the Funeral Director: After this certificate has heen sinned by the attention. in the past 12 months?

1 Yes 2 No signed by the at id be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Obstructive Pulmonary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No page 2 nronco Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d, Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an D51596 who completed cause of death (Item 23a) (Type, Print)
avanav 7845 Dakwood Road Glen Burnie MD2106, Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34833 Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month P^{M} 5:00 2012 10 Medical Robert Joseph Owens 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **Baltimore** Stella Maris Hospice cial Security Number 6. <u>Timonium</u> If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 01/02/1953 Months Min Director 1 X M 2 □ F 218-58-8310 59 Maryland Yrs Usual Residence of Decede filed within 72 hours efter death with the Merylend il Hyglene.

other then "neturel", or Items 23e or 28e-f show vent, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irector 1X☐ Yes 2 ☐ No Horntown <u>Accomack</u> ₫ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PO Box 542 23396 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Ves 2 NoArmy If Yes, Give Year or Dates. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 V No Specify. Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Worker Steel Mill permit. Page 1 and 2 should be filed w Department of Heelth end Mantel Hyg Importsnt: If Item 27 Is marked othe sny Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Bernard Owens Regina Elizabeth Ferris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 542, Horntown, VA 23396 Helen M. Owens / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/30/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Dorota Marshall Dow te Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liquiry that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): ettending physicien for use as the burle Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death signed by the ef be deteched for 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No 1 Yes 2 - No Hospitel or Attending Physicien: 1
 24 hours after death.
 Funerel Director: After this certifice Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 K Other (Specify) **HOSPICE** 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA I Director: After this ad in by the funerel d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending injury Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled Medica To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The defice of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of q 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) NOV 0 1 2012 32. Registrar Signatus

DHMH 17 Rev 06-2011

State Registrar

OWENS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER OGLE M ECIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Carroll Westminster If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. 5. Social Security Number 212-34-8878 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours July 13, 1935 Virginia 77 Director 1**X** M 2 □ F 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Carroll 1 Yes 2 X No MD Finksburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21048 USA Funeral 2432 Sandymount Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. Builder Elementary/Secondary (0-12) College (1-4 or 5+) Contractor 6th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Farmer ည Heath Ogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2432 Sandymount Road Finksburg MD 21048 Gloria Ogle /wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 11/6/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Service Licensee 21. Signatu Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the thin. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death cances Immediate Cause (Final Metastatic ESOPHAGES Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No Thromboatoperi 24a. Was an autopsy performed? Yes 2 XN After this certificate has filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 \(Yes \) 2 \(No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral L Medical to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number pumulia, MD D 0 51705 10-30-2012

State Registrar

DHMH 17 Rev 06-2011

NOV 0 1 2012

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 349 Mall with DR

ORIGINAL

westminster MDd157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Physician/ 3:50 A. M 2012 Byung Moon Park October Medical 4b. City, Town, or Location of Death
Lutherville 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore 747 Leister Drive 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Y March 2 If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Secul, S. Korea **Funeral** Min. Months Days Hours 1 🔀 M 2 🗆 F 51 Yrs. 215-02-0092 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---" any injury or other than "---". 10a. State 10b. County Director Lutherville 1 Yes 2 No Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 Funeral South Korea 747 Leister Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 Never Married 2 Married 1 Yes ZNNo If Yes, Give Year or Dates. Completed by 1 ☐ Yes 2 X No Specify: Specify: Korean 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Jeweler self employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Soon Nam Kwon ဂ္ Il Soo Park 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 12 Brook Hill Court Cockeysville, Maryland 21030 Mr. Han Gyung Yu/bro.in law 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition October 31 Dulaney Valley 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 2012 <u>Memoria1</u> Gardens 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Dcensee 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gliobl nenthe Physician. a disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 🗌 No 1 Yes 1 🗌 Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 X No 1 🔲 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) Manner of Death 28h Time of 28c. Injury at 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 3 ☐ Suiciae 4 ☐ Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R125828 10/26 cura 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Lewis, Gan Battimere, m

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 1 2012

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PETERS Month HENRY ZOAM 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square Roseda Baltimore FRANKLIN HOSPITa If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 13, 1928 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Baltimore, MD. Director 215-22-5602 1 X M 2 □ F 84 er then "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct Baltimore County Parkville 1 Yes 2X No Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd. 21234 United States 12. Was Decedent Ever in U.S.
Armed Forces?U.S.Army
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. δ 1 XNever Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes Give White 3 Divorced Year or Dates Korean War Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trust Clerk Baltimore City Govt. should be filed with and Mental Hygien 7 is marked other th 02 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Frank Peters Gertrude Elisabeth Just 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2249 Locksley Arch Virginia Beach, Virginia 23456 Mr. Carl J. Khalil (Nephew) Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State Wednesday, (Baltimore County) Oct. 31, 2012 Owings Mills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest V.A.Cem. 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Green's Jeffrey L. Gair, Sr. FSP-2, Name and Address of Facility es Funeral and Cremation Center, P.A.

Peacetul Alternatives Funeral and Cremation Center, P.A.

Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Ptv 1. Enter the disease, or do shock, or heart failure. List only Immediate Cause (Final mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Betwe DIAC Priysiciani ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DIABET Sequentially list conditions, Examine if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inureral director, page 2 should be detached for use as the burkal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐼 No Month 5 Other (specify) Day Pregnant at time of death 1 L Yes 2 b 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No ည 1 Inpatient 2 TER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D20649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOWIE YORK RD LUTHERVILLE TIMONIUM MO 21093 JOHN

State Registrar 31. Date filed (Month, Day, Year) NOV 0 1 2012

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32. Registrar's Signature

12-07413 Andy Price Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 34837

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Physician		Decedent's Name (First, Middle)	Month Day Year									3. Time of Deat	:h		
ledical Examin		Andy Price								Septemb	er 30, 20	12		1943 hrs	
		la. Facility Name (if not institutio	n, give street and n	umber)		b. City, Tov	n, or L	ocation of	Death		4c. C	ounty of	Death		
		1210 Steelton Avenue	•			Baltimo	_								
Funeral	7	5. Social Security Number 1171	6. Sex	7. Age (In yrs. la	ast birthday)	If Under				8. Date of B	irth(MM/DD)/YYYY)	9. Birth Foreign	place (State or	unk
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certi	<u> </u>	past 12 months?		nant at time of de	oth =	her (Specif				,					1
Box 687 ne death certific the attending 1 hed for use as the	Physician	1 Yes 2 No 9 Un	known 9 Unk	nown		1 1 1	· —								
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Rec The I ficate	ခြဲ				<u>.</u>						2 No	1	✓ Yes	2	No
certi	8	25. Was case referred to medical examiner?	Hospital:		1		10	of Death (Other		nly one) Home 5	7 p:		6 Oth	Coope	
Yhysio	2	1 ✓ Yes 2 No	'	Inpatient 2	ER/Outpatien		`			28d. Describ				Scene	
ing Ph		27. Manner of Death 1 Natural 5 Page	(Mon	e of Injury th, Day,Year)	28b. Time of	· ·	_	y at Work′	- 1	unkno		Occurre	su .		
ior teath tor:	#	- Fell	stigation	9-30-12	fd 19:	25 pm		es 2 🗶							0.11
Division tal or Attendi rs after death. al Director: /	읡		id not be	ace of Injury - At h				uilding, etc	c. 2	28f. Location or Town_	(Street and , State) 12	10 S	tee]	al Route Numb	er, City B.
Division the Hospital or Attendin hin 24 hours after death the Funeral Director: A	Certification:	4 Homicide	ermined (Specify		ouse/Ro					altim					
2 4 -		(Official offi)	hysician: To the b	est of my knowled	ige, death occu	rred at the ti	me, da	te and pla	ice, and o	due to the ca	use(s) and	manner	as state	d.	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	Medical		aminer: On the basis		and/or investiga				wired at	ule une, da					
	Ž∣	29b. Signature and title of certifi	er					number	OCME					th, Day, Year)	
		The land	Him	TR	me -		O.C.N	Л.E.			Octo	ber 1,	2012		
	ŀ	30. Name and address of person													
		Theodore M. King, Jr	., MD. Assis	tant Medical	Examiner	900 W. E	Baltim	ore Str	eet, Ba	Iltimore, I	MD 2122	3			
Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Signat											
Registr	ar	<u>NOV 0 1</u>	2012 /2	www.		Kal									
DHMH 17 Rev 1/200	01		144		ORIGINA	L									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 34838 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29 1202 A Andrew Peete, Jr. 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours Min. **Director** 412-54-3925 1 X M 2 🗆 F 75 October 4, 1937 TN Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Landover 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 Village Green Drive 20785 US Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S er than "natural", or iter the Medical Examiner 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify **Black** Specify 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Andrew Peete, Sr. Frances Peete 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie H. Peete/Wife 1505 Village Green Drive, Landover, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 7, 2012 Cedar Hill Cemetery Suitland, MD 21. Signature of Fu x ral Service Leans 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 3 disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physiciar Physician/Medical P.O. Box 68760 Jse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Pregnant at time of death Year 9 Unknown Hospital or Attending Physician: The law requires that the signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been signated bage 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗌 No Yes ☐ Yes completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only op 29b. Signature and titl 0 29d. Date signed (Month. Day. Year 10-29-2012

State Registrar who completed cause of death (Item 23a) (Type, Print)
WQ 8118 Good Luck Road Lanham, Mary Land 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 p^M Earle John Pearce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 31 Gravelo Circle Middle River Baltimore 8. Date of Birth (Month, Day, Year) 07/07/1951 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Country) Unkn. Days Hours Months 1 XM 2 = F Director 322-44-3062 61 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31 Gravelo Circle 21220 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Pearce Vera Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sho Department of Health an Important: If item 27 Is any injury or other trau 31 Gravelo Circle, Middle River, MD 21220 Nancy Pearce / Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/1/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DorotaMarshall 1 Maryland Cremation Services, PoBox 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause in each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to r as a conseque Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day 4 Pregnant a Pregnant at time of death 5 Other (specify) Year the detached Division of Vital Records, P.O. ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate | 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21/2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mapher of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending iniury within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year, rson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
NOV 0 1 2012

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Physician/ Month Somei 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death County of Death amor 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** ntry) Carolina Months Min. Director Bouth Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f shoi other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) l Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within 11 cashier/manager K-Mart Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fermam Wesly Toney Ebber Dean McKinney Important: If item 27 is mark any Injury or other transmissions. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Demarest/daughter 800 Locust Street #1 Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signatur Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Mernsclende Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the b IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ě Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Unursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Que the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print CAMPO-DEE MID

Registrar

State

NOMAN

31. Date filed (Month, Day, Year)

503

Registrar's Signature

THANKU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, 3. Time of Death Physician/ Tie bert Les Medical Facility Name (if not institution, 4c. County of Death **Examiner** A Medica Ltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 74 212-34-5173 **Director** 1 □**X**M 2 □ F 2,1938 Dct Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State notified at Director 1 🗌 Yes 2 🕇 No Baltimore Md. Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe must be Funeral 21237 U.S.A. 1416 Lancelot Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. the Medical Examiner Armed Forces?
1

Yes 2 □ No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12th 2yrs. Auto Industry Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H
27 is marked of
traumatic ever Rose Malecki Charles Howard Riebert, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1416 Lancelot Drive Rosedale, Md. 21237 Gloria H. Riebert / Wife Department of Health Important: If item 27 any injury or other tronce. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 Burial 2 Cremation 3 Removal from State St.Stanislaus Cem 2, 2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Atherosch Onset and Death Immediate Cause (Final CLRONARY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed pue for use as the burial-train Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death ☐ Pregnant a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 🗌 No ပ ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check within 24 only one 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDNORTH GREENE ST Baltimole, MD 21201 TAFEN -WAND

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

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Danielle	Renee	Robinson		

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	1- For State Certificate of Death Reg. No.									. 3404			
Physici Medical Exam		Decedent's Name (First, Middle Danielle Ren	. ,	son						Date of Deat Month October 20	h Day Yea		3. Time of Death 0757 hrs
and .		4a. Facility Name (if not institution 1807 Summit Avenue		umber)		4b. City, To		ocation of		october 20	4c. County of		atv.
Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Unde	•	If Under	24Hrs. 8	. Date of Birt	h(MM/DD/YYYY		
Director		215-98-2786	1_M 2XF		32 Y	Months		Hours	Min.			Foreign	1
		Usual Residence of Decedent	·		32 '	3.				07-26-	-1980		MD
r 20y		10a. State 10b. County		- *	Town or Loc								10d. Inside City Limits
Aaryland 28a-f show	5	MD Balt	imore	Ha	aletho	rpe							1 Yes 2 No
Maryl 28a-1	Director	10e. Street and Number			10f. Zip Code					g. Citizen of Wh	at Coun	try?	
th the 23a or		1807 Summit Ave				21	227				USA		
eath with the Maryland items 23a or 28a-f sho ust be notified at occe,	Funeral	11. Marital Status 1 Never Married 2 XM		cedent Ever in U.S orces?		as Deceder Yes, specify				y Yes or No- an, etc.)	14. Race White		an Indian, Black,
er dez			1 Yes	2 X No	1	Yes 2	₹ No	ana aifu		,			White
urs afi tural'	d b	15. Decedent's Education (Spec	or Dates:		16a. Decede				ind of work	done	Specify: 16b. Kind of Bus	siness/In	
72 ho	ompleted	Elementary/Secondary (0-12)		1-4 or 5+)	_	nost of work naker	ing life. [DO NOT u	use retired)		Owna I	Iomo	•
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ID 21215-0036 should be filed within 72 hours al and Mental Hygiene. 7 is marked other than "oatural natic evect, the Medical Examio	ပ	17. Father's Name (First, Middle, Robert Meredit	*				18				laiden Surname)		
212 uld be Menta marks	o Be	19a Informant's Name/Relationsl Shaun Robinson		<u> </u>	19b. Maili	a Address	(Street a				t Ferreb		7in Code)
O & 5 2 2 2		Shaun Robinson	,`husband 		18	07 Sur	mit	Ave.	Hal	ethor	ber, City or Town De, MD.	2122	27 oode)
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal fr		lace of Dispo rematory or of Lanti					ate	20c. Location -		
Baltimore, permit. Pages lar Department of Hee Important: If ite	Į	4 Donation 5 Other Sp	_	At	lanti	c Crem	ator	У	10-2	4-201	2 Glen	Buı	cnie, MD
3alt ermit. Separti mport		21. Santur of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc.											
	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Medical		 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone and Meprobamate Intoxication 											Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		one and] a consequence of		amate	Into	oxica	ation			-	Death
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8760, ificate be ex. ig physician is the burial -	Medi	IF FEMALE:		outcome of pregn		er me,	675.	, 11	10 12		23d. Date of d	1-15	
	51	23b. Was decedent pregnant in the past 12 months?	e 1 Live b	pirth	2 🗌 F	etal death	3	Ectopic p	pregnancy		Month Month	Da	ay Year
Box 6876 e death certificate the attending phy ed for use as the t	sici	1 Yes 2 No 9 ✔ Unk	I 'H	ant at time of dea	oth 5 C	ther (Specia	y)						
D. B.	Physicia	Part II. Other significant conditi	9 Unkno		sulting in the	underlying	ause niv	en in Part		23e Did tob	pacco use contrib	ute to th	ne cause of death?
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of Vital Records, og Physician: The law requirement in the this certificate has been si neral director, page 2 should be	Completed				· · · · · ·				_	24a. Was a	n 24b. W	ere auto	ppsy findings available
e law e has l	립									autops perform	n <u>ed</u> ? de	eath?	mpletion of cause of
/ital Rec ysician: The nis certificate director, page		25. Was case referred to medical				2F	Place of	f Death (C	Check only	1 Yes 2	No 1	✓ Yes	2 No
Vita ysicla his cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2 1	ER/Outpatier		101	hor -	Nursing Ho		Residence 6	Other:	Scene
og Ph log Ph After ti uneral	- 1	27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. Time of	Injury 28	c. Injury	at Work?	28d		ow injury occurre		
ion teath. tor: /	aţio	Natural 5 Pend 2 X Accident Inves		0-20-12	fd 7:3	0 am	1 Yes	s 2 X N	No su	bject	took dr	ugs	
Division tal or Attendi rs after death. al Director: A	Certification:	3 Suicide 6 Could	not be 28e. Place	e of Injury - At hor	me, farm, stre	et, factory, o	ffice buil	lding, etc.	- 1	or Town, Sta	ate)1807 S1	r or Rura	Route Number, City
ospita hours uoeral		4 Homicide	mined (Specify)							Lethor	rpe,MD.		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use at	Medical	(Check only one) 1 Certifying Ph	ysician: To the bes	of examination and									
rei F	Me	29b. Signature and title of certifier	and manner s	tated.		29c.	icense r	number			29d. Date signe	d (Mont	h, Day,Year)
		~ / /	/ (D.C.M.	E.		October 21, 2012			
04.1	1	30. Name and address of person v			•								
OCNE			Deputy Chief M			W. Balti	more S	Street, E	Baltimore	e, MD 212	223		
St Regist													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 2

			For State Registrar 1. Decedent's Name (First	st, Middle. Las	<u> </u>	Marylan	d / Depa	artmer tificat	nt of H	lealth Death	and N		Reg. No.	2012	3 4 8	
	Physicia				3CHKiDT							Month	Day		11:36	L M
	Medic Examin		4a. Facility Name (if not in					4b. City	Town, or	Location	of Death	OCTOBE		County of Deat	100	
			U ZROMÍTMB	UIHZAL	34 yota	oical c	EHTER	CI	GLEH BURLIE				14	URAZY	JJOH	
Ž.	Funeral Director		5. Social Security Number 215, 28, 2961 Usual Residence of Dec	er 6. S		Age (In yrs. la		If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)		thplace (State or untry) MD	Foreign
	and show at	ō		. County		10c. City	, Town or Lo	cation							10d. Inside Cit	y Limits
	Maryla 18a-f rtified	Director	MD A	NNE ARUI	NDEL	PAS	ADENA								1 🗆 Yes	2 XX No
	a or 2 be no		10e. Street and Number					10f. Zi	o Code				10g. Citi	zen of What Co	ountry?	
	h with	Funeral		ONTOWN !	RD BOX 1129				223					USA		
9036	filed within 72 hours after death with the Mayland fall bygiene. I hygiene. I other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 3 XXVidowed 4		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	XX Vo	l I	f Yes, spe	cify Cuba	spanic On n, Mexical Specify	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: WH		
21215-0036	within 72 hor giene. er than "nat t, the Medica	Completed			ducation ade completed) College (1-4	or 5+)	life. D	lent's Usu kind of wo O NOT us OMINIS	erk done a eretired)	luring mos	t of work	ing		nd of Business	/Industry	
and		To Be (17. Father's Name (First, ANTHONY ESWO							18. Moth		e (First, Middle,		Surname)		
	2 sho Ith an 27 is r trau		19a. Informant's Name/F		ype, Print) SO l	1	1	~				al Route Number			p Code)	
_	Page 1 and ment of Hea ant: If item: ury or other		20a. Method of Disposition 1 ☐ Burial 2 (XX) 4 ☐ Donation 5 ☐	remation 3	Removal from St	ate	lace of Dispo emetery, cren VIEW CRI	natory or	other plac		10.18.	Date .2012		cation - City or		
Balt	permit. Page 1 Department of Important: If it any injury or c		21. Sign (ra) f Funeral	Service Lig	1	M01148				HOME.		BURNIE, M	D 2106	51		
P	nysician Medical		23a. Part 1. Enter the di shock, or heart faild Immediate Cause (Final disease or condition resulting in death)	seasa or com ure. List saly o	tada .s	tuion	WIT23					or respiratory ar	rest,		Approximate Interval Bety Onset and D	veen Jeath
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Box	requires that the death certificate, been signed by the attending phys should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 No 9 ☐ Unknown	hs?		th 2 🗌 Feta nt at time of c	al death 3	Ectopic Other (s		у				23d. Date of de Month		'ear
s, P.O.	ires that th signed by Id be detad	d by Ph	Part II. Other significant			th but not res	ulting in the u	ınderlying	cause giv	en in Part	: I.				o the cause of de	
Division of Vital Records,	Hospital or Attending Physician: The law requires that the 24 hours after death . Funeral Director: After this certificate has been signed by the telely filled in by the funeral director, page 2 should be detach	Complete	202402	V4749	\							24a. Was auto perfe 1 \(\subseteq \text{Yes}	psy ormed?	prior to death?	utopsy findings a completion of co	vailable ause of
<u>a</u>	ertific ector,	Be (25. Was case referred to examiner?	medical	Heenitali						ath <i>(Chec</i>	k only one)		<u></u>		
>	ling Physician:). After this certific funeral director,	은	1 Yes 2 No		Hospital: 1 X In 28a. Date of	patient 2 -	ER/Outpatier			4 ∐ N	lursing H	ome 5 Resi			cify)	
o uo	Attending Prdeath. ctor: After to the funerance of the fu	Certificate;	1 Natural 5 2 Accident	Pending Investigatio	<i>(Month,</i> n	Day, Year)	injury	M	28c. Injury work 1 🗌] No	28d. Describe	now injury	occurred		
Divisi	pital or Attend ours after death eral Director: / filled in by the		3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of	Injury - At ho , etc. <i>(Specify</i>		eet, facto	y, office			28f. Location (City or To		Number or Ru	ıral Route Numb	er,
	To the Hospir within 24 hou To the Funer completely fill	Medical	(Check 2 1	Medical Exam	rsician: To the bes niner: On the basis ase Practitioner: T	of examination	and/or invest	tigation, ir	my opinio	on, death o	occurred a	t the time, date	and place,	and due to the	cause(s) and mai	nner stated.
	To th Within To th comp		29b. Signature and title of		1/1/				c. License					e signed (Mont		
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			30. Name and address o		completed gause	of death (Item										
			J tevel	J. Sch	mark	1-1	<u> </u>	1014	71920	0 14	RIVE	UZID,	BURI	ME, MD	50161	
	Sta Registr		31. Date filed (Month, Da	v () 1 2		jistrar's Signa	ture	arka								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ lliam 0720 M 2012 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. altimore DICE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 220-26-805 Hours Director 1 №M 2 🗆 F th and Mentel Hygiene. 27 is merked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location within 72 hours efter death with the Meryland 10d. Inside City Limits Director 1 Nes 2 No altimal 10e. Street and Numbe \$510 10f. Zip Code 10g. Citizen of What Country? Funeral errace Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: B 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Struc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ည lliams P permit. Pege 1 end 2 should be Depertment of Heelth end Men Important: If item 27 is merke any injury or other traumetic 90ces. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Neurial 2 Cremation 3 Removal from State cemetery, ci matory or other place, altimore. 4 Donation 5 Other (Specify) UM 21. Signature of Funeral Service Liquis 22. Name and Address of Facility MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ pulmmale ase or condition KINS Medical resulting in death) Due to (or as a con-uence of): Examiner Obstructu diteras wonic cons Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of ettending physicien end I for use es the buriel-trenslt or Attending Physicien: The lew requires that the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day ate has been signed by the page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospitel or Attending Physicien: The within 24 hours efter deeth.
To the Funeral Director: After this certificate I completely filled in by the funeral director, peg 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural
Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 30 OCTUSE 27 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.50

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

CHAZIES W)

Please Type or Print in Black in egible in Registration All Copies Are Legible.

State of Maryland / Department of Lealth and Mental Hygiene
amend #1 per / Department of Lealth and Mental Hygiene
Certificate of Death

Reg. No. 2012 For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) Mae Bell Strong 2. Date of Death Physician/ Of teles 2012 Medical Mabel 1 Strong 4a. Facility Name (if not institution, Examiner give street and number 4b. City, Town, or Location of Death 4c. County of Death Health Ellicott Ellicott Howar Year If Under 24 Hrs. 8. Date of Bigh 7. Age (In yrs. last birthday) Sex 9. Birthplace (State or Foreign Country) **Funeral** 075-30-148 Months 1 M 2 N **Director** 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Ves 2 No essu Howard 10e. Street and Number 10g. Citizen of What Country? 20794 USA 10164 DVO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 1ach 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tollewat Be 17. Father's Name (First, Middle, Last) မ pfield Nilliam Mae 20794 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) strono 10164 ion na OVOOR 20a. Method of Disposition 20b. Place of Disposition (Name of Date Town, State 20c. Location - City or cemetery, crematory or other place) ☐ Burial 2 remation 3 Removal from State 12012 Other (Specify) 4 Donation 21. Signature of Fineral Service Lice .0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Neumousa Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and -transi that initiated events resulting in death) Last Due to (or as a consequence of): the burial been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death Year 1 L Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 252 47 6 29b. Signature and titl ٩ Maiden Choice love and address of person who completed cause of death (Item 23a) (Type, Print) 720 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State NOV 0 1 2012 Registrar

Please Type or Print in Black Indelible link, Finsure All Copies Are Legible. amend #19a Per INF G933 | State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TURCIS Month Physician/ 2 Sear 10:02 PM Medical or Location of Death 4c. County of Death **Examiner** Baltimore Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 M 2 □ F **Director** Yrs. 28a-f show 10c, City, Town or Location 10d. Inside City Limits ms 23a or 28a-1 shormust be notified at Completed by Funeral Director 1 Yes 2 ☐ No t more 10g. Citizen of What Country? Rosedale 15A permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural" 3 Divorced 4 Divorced of Health and Mental Hygiene.
If item 27 is marked other than "natu
or other traumatic event, the M-dical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Oglege (1-4 or 5+) Elementary/Secondary (0-12) Biomedica echnicar Be ather's Name (First, Middle, Last မ an Department of Health ar Important: If item 27 is any injury or other trau 360 20b. Place of Disposition cemetery, cremato Burial 2 Cremation 3 Removal rom State Noodlawn, 4 ☐ Donation 5 ☐ Qther (Specify) ure of Fun al Ser 61 Nat sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a. Part 1. Enter the d shock, or heart fail Approximate Interval Between Onset and Death BRONCHIAL Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year Month Day Pregnant at time of death
Unknown 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? NSON 24a. Was an autopsy performed? Yes 2 No 51 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 6 🗌 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (*Month*, *Day*, *Year*)

10 -31-20/2 29b. Signature and title of certifier 2411. W BELVEDERE AVE #201 BALT. MD 2121 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State NOV 0 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	State Registrar					Cei	artment o rtificate	of De				Reg. No	0.0	12	348
	1. Decedent's Name (F	irst, Middle,	Last)								2. Date of I Month	Death Da	av	Year	3. Time of De
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	4a. Facility Name (If no		Ŭ.				4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birthpi								
	Overlea I 5. Social Security Numl		& Reha			st birthday)							Q Rirthr	place (State or F	
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runeral	11. Marital Status 1 □ Never Married	un.	K Arme	ed Forces? /es 2 □ N	lo		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White,								
2	3 ☐ Widowed 4 ☐	_	If Yes	s, Give or Dates:	u	nk	1 □Yes 2√X No Specify: Specify: b1:					ack			
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completed	Elementary/Seconda			ge (1-4or 5-	+)		e. DO NOT use retired)								
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2	17. Father's Name (Firs	st, Middle, La	ast)				un	1k 18	3. Mother's	s Name	e (First, Mido	dle, Maidei	n Surnar	ne)	
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	19a. Informant's Name Overlea H				tar		ng Address <i>(S</i> 6 Bela:							, State, Zip 206	o Coae)
	20a. Method of Disposi		u Kena	D Cen	20b. Pla	ace of Dispo	sition (Name	of	oau i		Date	_			own, State
	1 ☐ Burial 2 ☐ C	remation 3			ce	metery, crei	natory or othe	er place)	!					,	, =
	4 Donation 5 Worker (Specify) in state 21. Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street														
	Roi	Ronald S. Water Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201													
	23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.												Approximate		
	shock, a heart failure. List only one cause on each line.													Interval Betwe Onset and Dea	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 51 MM DNJ CHARLES W PM 11.47 01 Medical 0 20/2 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PERRING rich y Baltimore Baltimore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 216-82-1754 Director 1 XM 2 - F Dec 6, 1960 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Balt imore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1626 Gray Place 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 No unk 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Perring Pkwy 1801 WEntworth Road Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ♥ Other (Specify) in state Rc na I ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Raltimore. MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Encephalo Departie disease or condition Medical resulting in death) Due to (or **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine 1 trmon and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the atte d be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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EYTAN ST

29d. Date signed (Month, Day, Year)

308 BALTIMORE MD 212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** Wesley Singleton Sr. 2012 2:00a. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) 3634 Dolfield Ave Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 10 Director 219-12-5263 88 08 SC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shov idical Examiner must be notified at ↑Y Yes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21215 U.S.A. 3634 Dolfield Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Garner John Singleton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If Item 27 i <u>3634 Dolfield Ave, Baltimore, </u> Md 21215 Lucille Singleton-Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ₽ 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. Baltimore National 11/5/2012 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Spepity) 21. Signature of Funeral Service See 22. Name and Address of Facility March F/H West Md 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Xea/S SIMI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical the ast attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a Ö 9 Unknown 9 Unknown مَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, by 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has performed? 1☐ Yes 2☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ala del Tava Koli 12200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depa		lental Hygi	ene	01050
			Registrar 1. Decedent's Name (First, Middle, Last)	tificate of Death		g. No. 2 U 2	34850
	Physicia		Sandra J. Shortall		2. Date of Death Oct. 27	Days Varia	3. Time of Death 6:30 AM
- Stere	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	000. 27	4c. County of Death	0.30 A
			2103 Pot Spring Road	Timonium		Baltim	ore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	9. Birthp	lace (State or Foreign	
	Director		218-34-2237 1 □ M 2 🗓 F 68 Yrs.		Jan. 10	, 1944 Ba	Ltimore, MD
	land shov d at	ţ	10a. State 10b. County 10c. City, Town or Loc	ation		1	0d. Inside City Limits
	Mary 28a-f otifie	irec	MD Baltimore Timoniu	m	_		1 ☐ Yes 2 🛣 No
	th the 3a or t be n	al D	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
	ath wi	Funeral Director	2103 Pot Spring Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21093	oify Vec or No-	USA	
9	or ite	by F	1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - America Black, White, e	tc.
8	urs af tural" al Exa	ted	3 Widowed 4 Divorced Year or Dates.	Yes 2 🔀 No Specify:		Specify: Whit	:e
15	72 ho n "na"	Completed	(Specify only highest grade completed) (Give k	lent's Usual Occupation kind of work done during most of workir D NOT use retired)	ng 1	6b. Kind of Business/Inc	lustry
212	vithin giene. er tha		Elementary/Secondary (0-12) College (1-4 or 5+)	memaker		Own Home	
ng	filed val Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
yla	ild be Ment arke	မ	John Semma	Helen	Malsew		
Mar	2 shouth and the shou		1 1	g Address (Street and Number or Rural		-	
<u>ه</u>	Healt Healt Hem 2		20a. Method of Disposition 20b. Place of Dispos	Pot Spring Road		m, MD 21093 Oc. Location - City or To	
mo	Page 1 nent of nt; If i			natory or other place) Nov	2,	Timonium,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Janeral Service Liceusee 22.	Name and Address of Facility	of Dula		
Ш	2 G E E 9		chael J. Flagle	Name and Address of Facility mmon Funeral Home W. Padonia Road	Timoniu	m, MD 21093	IIIC.
	March Services		shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or	r respiratory arrest	t,	Approximate Interval Between
إلعنا	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ung cancer		-	Onset and Death
	Examiner		Due to (or as a consequence of):)			
	· ·	iner	Sequentially list conditions, b. the to (or as a consequence of); cause. Enter Underlying			i i	
	cuted	Examiner	Cause (Disease or injury that initiated events c.				
_	ite be executed hysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
760	law requires that the death certificate be executed ras been signed by the attending physician and e 2 should be detached for use as the burial-transi	ledic	d		_		
89	certifi ending use a	N/N	IF FEMALE: 23b. Was decedent pregnal. 23c. If yes, outcome of pregnancy 1	[23d. Date of delive	ry
Вох	requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me		Other (specify)		Month	Day Year
o.	at the d by ti detach		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I	22a Did taba	cco use contribute to the	course of death?
S, P.	signe signe	d by		, 5		2 No 3 Prob	
Records,	v requ	Completed			24a. Was an	Z4b. Were autop	sy findings available
ဒ္ဓင		шо	,		autopsy performe	ed? death?	pletion of cause of
	ysician; The is certificate director, pag		25. Was case referred to edical examiner?	26. Place of Death (Check		1 les	z 🗀 NO
Vital	Physic this corral dire	유	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Hor	me 5 🖺 Residen	ce 6 Other (Specify)	
Division of	ling \After fune	Certificate:	27. Manne Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
SIO	I or Attend after death Director; / d in by the	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street		28f. Location (Stre	et and Number or Rural I	Route Number,
D	tal or		building, etc. (Specify)		City or Town,	State)	
1	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check (Check 2 Medical Examiner: On the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investig	ccurred at the time, date and place, angation, in my opinion, death occurred at	d due to the cause the time, date and	e(s) and manner as state	d. se(s) and manner stated.
I)	o the lithin 2 the lomple	W	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, a 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	ce, and due to the	cause(s) and manner as st	ated.
	F S F 8		Da John Man Man	DC COHO	290	d. Date signed (Month, D	() ()
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)		30 0	010
	0		Richard Schraeder, M.D. 7501 Osler D	or. Towson, MD 2	1204		
	Stat Registra	e ir	31. Detection (Month, Day Year) Server S. Agarda				
	- 3.00						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clarence Stevens 20⁴2 4:00 A_M October 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cranberry Cottage Glen Burnie Anne Arundel Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, ay 21 1 🗶 M 2 🗆 F Months Days Hours Year) Country) 95 Mass 026-01-1474 1917 Director May Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ death with the Maryland Director must be notified 1 🗆 Yes 2 🛣 No Crofton Anne Arundel Maryland 10f. Zip Code ь 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral USA 21114 1519 Ashburnham Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Procter & Gamble 12 4 Chemical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilson and Mental Florence ည Sr. L Clarence Wesley Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 1519 Ashburnham Drive, Crofton, MD 21114 Christine Ann Stevens(daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematroy, Inc. Oct. 30,2012 Baltimore, MD 21. Signatur f Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, PA <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between t De Immediate Cause (Final Physician/ 10 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Live Birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day Year Yes 2 No the 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 2 performed' 2 [LN 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 DNo မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Death 27. Manner 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending e nous n 24 hours after deaun ne Funeral Director: Aff 1 Tes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

within 2

Registrar DHMH 17 Rev 7/2009

State

(Check

only one)

29b. Signature and

3

of_death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0200

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh g933 11-1-12 vt.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ October 9:32 PM James W. Staruh Medical 4a. Facility Name (if not institution, give street and number) Prince George's 4b. City, Town, or Location of Death Examiner aurel Regional Hospital Laure Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min Director 180-50-0340 1**XX**M 2 □ F 57 Aug. 19, 1955 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2X No MD Anne Arundel Laurel ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner must** 454 USA Henryton S. 20724 or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, I1. Marital Status Black, White, etc. þ 1 Never Married 2 X Married XX Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Fireside Plumbing, Inc 12th Ø Plumber Be . Father's Name (First, Middle, Last)

Michael S. 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Godish Sylvester Staruh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Diana M. Staruh/Spouse Henryton S. Laurel, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🛛 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/2012 Odenton, MD Arundel Crem. 22. Name and Address of Facility Donaldson Funeral Home. 21. Signature of Funeral Service Licensee P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of): physician ar resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe After this certificate I 2 1 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 **Y** No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident ours after death.

neral Director: Aft
filled in by the fur Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 10/32/2017 D16313 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Duser Barry Shapiro, MD Laurel Regional Hospital, Emergency Laurel, MD 7300 Van Dusen Rd. 20707 31. Date filed (Month 1 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / UT / Z State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Eugene M. Sartori Medical 10:30 A ctober 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Prince George's 9632 Gwyndale Drive If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Director 191 26 9255 1 XXM 2 □ F 78 Aug 2, 1934 PA Usual Residence of Deceder or then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Prince George's 1 Tes 2XXNo Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9632 Gwyndale Drive 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates ₩√11 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Retired US Supreme Court Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever t. Page 1 end 2 should be fill thent of Health and Mental tent. If item 27 is marked Augusta M. Recla Matthew Sartori 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan A. Sartori (Wife) 9632 Gwyndale Drive, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Importent: If it any injury or o 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 10/29/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 21. Signature Funeral Service To risee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Heart Diseas Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events use as the burial-tran resulting in death) Last Due to (or as a consequence of): igned by the ettending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death Month 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 1 🗌 Yes 2 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospitei Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occur To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouutchou, mo Jocelline 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Koualehon, M.D. 4041 Powder Mill Road, #600, Calvertion, MD August 2 Region's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} Kathryn Pilgert Solt 10 2012 6:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Eden Homes Assisted Living Montgomery Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Pennsylvania **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth (Month, Day, Year) 08/27/1930 Days Director 1 🗆 M 2 🖎 F 205-28-5143 82 Yrs Usual Residence of Decedent show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1X Yes 2 ☐ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6602 Greyswood Road 20817 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 0 1 Never Married 2 Married \$ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", Specify. Completed 3 X Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 I t of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Pilgert Emma Kathryn Greenfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Martha Solt / Daughter 5325 Yorktown Road, Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/30/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility -Dor<u>ota Marshall</u> Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician/ Failure to Thrive resulting in death) Medical Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Fitter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed Deep Venous Thrombosis 1 Tes should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has bage 5 autopsy performed?

1 Yes 2 No this certificate Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Aftert 28d. Describe how injury occurred M Natural 5 Pending I Director: A ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D.50534 10.29.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6801 Whitter Avenue, #205, McLean, VA 2210 <u> Thomas Masterson, M.D.</u> 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 26, Deborah Lynn Shenk 2012 7:20a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Care Towon Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Mor)th, Day, Year) 12/15/1955 218-72-3126 Director 1 M 2 A 56 Yrs Maryland Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director 1 XYes 2 No Aberdeen Maryland Harford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21001 USA 410 Spesutia Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) # Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife In Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Ruth Wassum John Norman t. Page 1 and 2 should by treent of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Spesutia Road, Aberdeen, Maryland 21001 Richard L. Shenk (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Company 10/27/2012 West Chester, PA 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 3 [

31. Date filed (Month, Day, Year)

only one 29b. Signature and t Certifying

of certifier

DHMH 17 Rev 06-2011

ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated rse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Month Physician/ Norman Joseph Swiston, Sr. 10:15A M Oct Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Golden Living Center Carroll Westminster . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 220-24-8442 **X**□ M 2 □ F 82 **Director** 5-31-1931 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Oueen Anne's Stevensville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral Terrapin Grove Rd., No. 21666 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1X Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white Yes. Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Business Travel Space Program Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph J. Swiston Anna Bozak other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 Department of Health a Important: If item 27 is any injury or other trat Norman Swiston Jr.-son Baldwin Park Dr., T4, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/12 Westminster, MD Central MD Crem ^{22. Name and Address of Facility} Fletcher Funeral & Cremation Funeral Service Li Main St., Westminster, MD 21157 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Physician/ ORBID disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ERERAL Exam Cause (Disease or injury VASCULA that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ☐ Pregnant ☐ Unknown signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 has autopsy death? 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifician Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Cify or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) 069

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State Registrar

Swe tson

mon

and address of person who completed cause of death (Item 23a) (Type, Print)

10

RNP 688C POOLS ROAD WESTHINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October Physician/ $20\overset{\text{rear}}{12}$ A^{M} 3:45 allust Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale Manor Care Rossville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country) Min (Month, Day, 1 - M 2 - F 97 Yrs 04-07-1915 New York **Director** 218-01-2037 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner manal bronce. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Baltimore Overlea Marvland 10g. Citizen of What Country? 10e Street and Number USA 21236 Funeral 4300 Cardwell Avenue Apt. 315 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carmela Ludovico ပ Daniel LaPenna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 37 Lake Drive Bel Air, Maryland 21014 Mrs. Rose Marie Gernhart -20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Intombment Gardens of Faith Cem. 11-02-2012 Baltimore, Maryland 22. Name and Address of Facility 5305 Harford Road Service Licensee 21. Signatur Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 0 Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical a consequence of Examiner Sequentially list conditions Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) tor: After this certificate has been signed by the the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medica Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 2 U N မ 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Certificate: Natural 5 \square Pending work? 1 \sum Yes 2 \sum No death. 2 Accident
3 Suicide after death Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and tle of certifier 0073005 who completed cause of death (Item 23a) (Type, Print) saa 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2012 Month 14:15 00 4b. City, Town, or Location of Death 4c. County of Death N/A zaltimore Medical Center 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6. Sex Months 1 🗆 M 2 🕱 F D.C. Yrs 09/14/1966 66 10b. County 10c. City, Town or Location Baltimore N/A 10g. Citizen of What Country? 10f. Zip Code 21216

34858 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ -laine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** University of MD 9. Birthplace (State or Foreign **Funeral** 218-42-2586 Usual Residence of Decedent Director or 28a-f show 10d. Inside City Limits 10a. State be notified at Director MD 1 XYes 2 No 10e. Street and Number 740 N. Poplar Grove #12G 23a Funeral must USA items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14 Race - American Indian Examiner Black, White, etc. 1 X Never Married 2 Married "natural", or þ within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Black 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Hotel Elementary/Secondary (0-12) College (1-4 or 5+) the Housekeeping 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Georgeanna Jackson Robert Sinkler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1012 Rosedale St. Balto., MD 21216 Taunika Hernandez (Dghtr.) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Baltimore, MD 11/3/2012 Zion Donation 5 Other (Specify) Funeral Home PA 21. Signeture of Funeral Society Licenses 22. Namos edins of acility Brown Jr. MD 21217 2140 N. Fulton Ave. Balto., 23a. Part 1. Enter the disease, or complete tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pnock, or hear/tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition asal Ganglia Intracerebral Hemorrhag Physician/ Medical resulting in death) Due to (or as a consequence) **Examiner** days 10 reumonio Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami unknown Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, Congestive 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes icate has been sig r, page 2 should k Completed Were autopsy findings available prior to completion of cause of 24a. Was an Kidney Disease Cardionyopathi autopsy performed' 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 Matural iniury 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie CRNP 2012 rou-Eller 3157 26 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w Baltimore, MD Greene St 22 S ou-Ellen 32. Registr State Registrar

12-07965 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Darius T Taybron State of Maryland / Department of Health and Mental Hygiene 2012 34859 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 20, 2012 Datius T. Taybron **Medical Examiner** Darius 4a. Facility Name (if not institution, give street and number) 4c, County of Death 4h City Town or Location of Death N/AJohns Hopkins Hospital Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Foreign MD 218-39-7197 Months Hours 9/9/93 Director 19 1 XM 2 F Yrs Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County Baltimore MD N/A Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21217 555 Dolphin St. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes African 4 Divorced If Yes, Give Yaar or Dates: 1 Yes 2 X No specify: 3 Widowed Specify: Amer ۾ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College Elementary/Secondary (0-12) College (1-4 or 5+) Student 17. Father's Name (First, Middle, Last)
Ronnie Taybron 18.Mother's Name (First, Middle, Majden Surname) Donna Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 555 Dolp ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolphin St., Balt., MD 21217 Donna Jones/Mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Trinity Cem. 11/1/12 1 X Burial 2 Cremation 3 Removal from State Balt., MD Donation 5 Other Specify: 22. Name and Address of Facility Hari P. Cl. 5126 Belair Rd, Balt., MD 21. Signature of Funeral Service Licensee er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician 23a, Part I, Enter the disease failure. List only one cause on each line /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ed by the attending physician and detached for use as the burial - transit vsician/Medical UNPENDED * AMENDED #1perME.G933.11/1/2012.WS#5perFH of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown ᅕ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b á Completed 24a. Was an autopsy performed page ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject shot 1 Natural FOUND: Division 1 Yes 2 ✔ No Pending Oct 20, 2012 1527 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be

lose F.Svs.PA D 21206-5105 Approximate Interval Between Onset and Death 23d. Date of deliver Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Other Nursing Home 5 Residence 6 Other: Certification Funeral Director: etely filled in by the 28f. Location (Street and Number or Rural Route Number, City Suicide or Town, State) 2502 E. Hoffman St, Baltimore, MD determined (Specify) Local Street 4 / Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. October 21, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV **ORIGINAL** OGME

3 Time of Death

1606 hrs

10d. Inside City Limits

1X Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 31 2012 Sundina DelGavio Trimble 12:05 A. M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1116 A Spalding Drive Bel Air Harford . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 1, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 218-18-6443 **Director** 1 □ M 2**X** F 87 Maryland 1925 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Director notified Maryland Harford Bel Air 1 Yes 2XNo 10e. Street and Number 9 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral United States 1116 A Spalding Drive 21014 of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vincent DelGavio Alice Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Edgar Trimble / Husband β05 <u>Willrich Circle Unit B Forest Hill, MD 21050</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 2012 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service dicensee Evans Funeral Chapel& Cremation Service-Bel Air 3 Newport Drive Forest Hill, Maryland 21050 X s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: be detached for use Live Birth 2 Fetal death If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 X No 9 Unknown Pregnant at time of death Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Tyes within 24 hours after death To the Funeral Director, Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Certifying Number Practification To the best of my knowledge, death occurred at the time date and place and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and use of death (Item 23a) (Type, Print) I VALLEY ROTIMONIUL Ve State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03:24 AM ctobes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore more 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Funeral Hours Director 1 M 2 M F Z 20 192 1 and 2 should be filed within 72 hours effer death with the Maryland of Health and Mental Hygiene.
Item 27 is merked other then "nature!", or items 23e or 28e-f shov other treumetic event, the Medical Examinar must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education ndusty ome 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during Secondary (0-12) College (1-4 or 5+) Ome Be 17. Father's Name (First, Middle, Last) UNK 18. Mother laiden Surname known 19a Informant's Name/Belationship (Type pern it. Page 1 and 2 sh Deportment of Health ar important: If item 27 is eny injury or other treu lichae Himore 20a. Method of Disposition 20b. Place of Disposition (Na cemetery, crematory pr Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) or 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ease or condition Medical resulting in death) Due to (or at a consequence of): Examiner Fungemic Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a sequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events sician and burlal-trans Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burla Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 cate hes been sig 7, page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မှ 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 8c. Injury at Certificate: within 24 hours after death.

To the Funerei Director: After tompletely filled in by the funer 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) preet October 30,2012 -000 ess of person who completed cause of death (Item 23a) (Type, Print) OF 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 8:58 am George Thomas 2012 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months Hours None **Director** 1 X M 2 🗆 F 26 10/31/1985 India 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director College Park 1 Tes 2 X No Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? ò ems 23a or r must be r Funeral 20740 India 4805 Cherokee Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? 1 ☐ Yes 2 **X** No 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Education Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie P. George Poovathumkal Chacko Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Robin Hood Court, Ellicott City, Maryland 21042 Jacob Thomas - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 X Removal from State Assumption Forane Cem 11/05/2012 Erumely, India 5 Other (Specify) Donation ature of Fundial Sorvice Ligensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. etu 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CERTIFICATION APPROVED BY NEDICAL EXAMINER Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and dedected for use as the burial-transit Cause (Disease or injury Division of Vital Records, P.O. Box 6876000 that initiated events resulting in death) Last Physician/Medical IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown is certificate has been si director, page 2 should Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 2 No ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral Magner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending SUBJECT FELL OFF BAR STOOL 1 Yes 2 No Investigation 9-21-2012 UNK 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7325 BALTIMORE AVE COLLEGE PARK, MD. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined RESTAURANT Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number

Registrar
DHMH 17 Rev 06-2011

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5		Zabiullah Ali, M.D.						Baltim	ore Stre	et, Balt	timore,	MD 21223			
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FEMALE: 28. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23c. If yes of the past 12 months? 23c. If yes, outcome of pregnancy 23c. If yes of the past 12 months? 23c. If yes, outcome of pregnancy 23c. If yes, outcome of death 23c. If yes, outcome of pregnancy 23c. If yes, outcome of death 23c. If yes, outcome of pregnancy 23c. If yes, outcome of	2	ੇ ਰੋਫ਼	lical	UNPENDEO	dAMEND	ED												_	_
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2012	760,	physic the bur	/Mec				me of preg	nancy				1			2		-		
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2012	89 J	ending use as	cian	past 12 months?	1'-		t time of de	2 ath 5	=		-	Ectopic p	oregnand	СУ		Month	Day	′	Year
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29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2012	P.O.	gned by e detach	þ	Part II. Other significant condit	ions contributi	ng to deat	th but not r	esulting	in the und	lerlying ca	ause giv	en in Part	I.				_	_	
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2012	ds,	seen sig	eted																
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2012	000	e has b	mp											perf	formed?	P d	eath?		
29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2012		rtifical			1					26.	Place of	Death (C	heck on		2 🖳	110			No
29b. Signature and title of certifier 29c. License number O.C.M.E. October 28, 2012	Vita	this ce I direct	20		Hospital: 1[Inpati	ent 2	ER/Out	patient :	3 DO/	A Of	her ₄ I	Nursing	Home 5	Resid	dence 6	Other: S	cene	
29b. Signature and title of certifier 29c. License number O.C.M.E. October 28, 2012	יסר	After		1 of Netweet	(1	ate of Injudently	ury Year)	28b. Ti	ime of Inju	·				8d. Describe	e how in	njury occurre	ed		
29b. Signature and title of certifier 29c. License number O.C.M.E. October 28, 2012	Sior	death ctor:	catio	- Perk	stigation	Dines of h	nium. At hu	ama for	m stroot					Of Location	/Ctroot	and Numba	r or Buso	Douto N	lumbos Citu
29b. Signature and title of certifier 29c. License number O.C.M.E. October 28, 2012	Divi	rs after al Dir led in	ertifi	dete	a not be		njury - At th	orrie, rari	iii, sireet,	ractory, o	ince buil	ulig, etc.				and Numbe	I OI Ruia	Noute I	diffiber, City
29b. Signature and title of certifier 29c. License number O.C.M.E. October 28, 2012	Hoani	24 hou Funer stely fil		29a. Certifier (Check only 1 CertifyIng P															
29b. Signature and title of certifier 29c. License number O.C.M.E. October 28, 2012	Tothe	within To the comple	edic	2 🖳	and man		mination a	nd/or inv	vestigation				rred at 1	he time, dat					
- aut un - Other			Σ	29b. Signature and title of certific	er)01)											, Day, Ye	ear)
		10		7 QU W	who completed		death /lta	2221		`	J. O. IVI.						, 2012		
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		W						,	ner 9	00 W. E	Baltimo	ore Stre	et, Ba	ltimore, N	MD 21	223			
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature					3:	Registra	ar's Signatu	ıre											

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21:56 M NICHOLAS OC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWAKT GEN COWMBIA COUNTY Howard Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year)1926 Pennsylvania Nov. 18, 1**X**XM 2 □ F Months Days Hours 209-18-6448 85 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Tes 2xxNo Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be 23a 6620 Washington Blvd. 21075 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married "natural", or þ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Combat Intelligence United States Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental H.
Important: If item 27 is marked ott
any injury or other traumatic even မ Vasil Tur Anna Vanda Cerula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Santarsiero / Nephew 216 Allen Street Dunmore, Pennsylvania 18512 20b. Place of Disposition (Name of cemetery, crematory or other place Arlington National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linunsee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring, Rd., Arbutus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician INFLAMMATORY RESPONSE SYNDROR MISTEMIC <u>weal</u> disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner BACTEREMIA Sequentially list conditions. ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of Exami OSTEOMYELITIS EFT and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a d be detached for the 1 ☐ Yes 2 ☐ Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FFICILE 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed? the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical rector, 26. Place of Death (Check only one) Be examiner? Hospital: 21 No 1 Tes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this of 27. Man of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie SYED, FATIMA N.D 0069644 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10659 1+16-H FATIMA COLUMBIA MD

DHMH 17 Rev 7/2009

State Registrar anature

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ :48 Joseph Wallace Weir, Jr. 2012 OC TOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE OF HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** Hours XXM 2 □ F 215-42-7287 Director 69 Yrs. Jun. 24, 1943 MD Usual Residence of Deced ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other treumatic event, t<u>he Medical Examiner must be notified at</u> 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 XXves 2 □ No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21157 1119 Old Westminster Pike 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hittman Materials & permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other treumasis. College (1-4 or 5+) Elementary/Secondary (0-12) Medical Components, Inc Material Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Hartle Joseph Wallace Weir, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1119 Old Westminster Pike, Westminster, MD 21157 Jacqueline M. Weir (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Evergreen Mem'l Grdns 11/5/2012 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Fuller Service Licenser 11605 Reisterstown Rd., Owings Mills, MD 21117 Paul Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ METASTATIC Medical resulting in death) Due to (or as a consequence of): Examiner EFRICATORY Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit RENA FAILURE Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 🕳 No Yes 2 M No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{NO Other (Specify)} \) HOSPICE 2 1 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 8c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Crutifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.b. KES 2012 CCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP SINAL HOSPITAL OF BALTIMORE 2401 W. (SOSAIN.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 4:55 ria 12 10 23 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner NIA TOWN salt more ctureca Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** Months 100M 2□ F 249-66-7611 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Dayes 2 No altimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2206 21216 Hue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 Ne If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Ves 2 No Specify þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Driver Movers 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type, Print) altimore, MD 5603 agra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 131/2012 Bathinoso etro 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Liminsee altimore, Wil MMS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) PLOSTATE CANCER /Medical Examiner Due to (or as e consequence of) Physician/Medicai Examiner ANGUIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): OST GOPOLOSIS Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 ☐ Yea 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 ☐ No 111765 25. Was case referred to-medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3⊡ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner death 1 Systural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attanding Physician: The law requiras that the death certificata be executed after death. attending physiclan and for use as the burial-transit Division of Vital Records, P.O. Box 68760, been signed by the should be detached has pege 2 this cartificate Director: After this cartific d in by tha funeral director, the Hospital within 24 hours a

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

3 Suicide 4 ☐ Homicide

29b. Signature and title of certifie

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8813 Walthe

State Registrar

edical

29a. Certifier (Check only one)

> AMA Day, Year) 2012 Month.

ASHRAG-32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5,20b,perFH,G933,11/1/2012,WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Emma Mildred Wilkins 0235 AM OCTOBER 26 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Levindale If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Days Hours 05/03/ Director 87 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Baltimore N/A MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral 740 Poplar Grove St. or items 23a USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Division Nursing Assistant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earlene Branson (Friend) 7907 Green St., Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park 11/5/12
King Fark 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Sign ture of Fu eral Service Licenson 22. Name and Address of Facility Brown Jr. Funeral Home PA MD 21217 2140 N. Fulton Ave., Balto., art 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List ofly one cause on each line. Approximate interval Between Onset and Death m diate Cause (Final Physician/ CARDIO PILLMONARY - sease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 6 months ANOXIC ENCEPHALOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). 6 months To the Hospital or Attending Physician: The law requires that the death certificate be executed HYPOGLYCEMIA Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie DOO 62 895 OCTOBER 26,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2334 Nest Belvedere Ave, BALTIMORE PAULINE DAL MD. 31. Date filed (Month, Dav. Year) /32. Registrar's Signature State 31 barker Registrar

Emma

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			For State	State of	Marylar		artment of F <i>rtificate of</i>		_	giene Reg. No	71117	34869
			1. Decedent's Name (First, Midd	le, Last)	-		in outo or		2. Date of De	ath		3. Time of Death
	Physici		Ruth Wenger						Month 10	22	y Year 2012	1:50 PM
	/Medio Examir		4a. Facility Name (If not institution	n, give street and num	iber)		4b. City, Town, o	r Location of Deat	h	4c.	. County of Death	1
			Manor Care Potomad	:			Potomac			Mc	ontgomery	
	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	nplace (State or Foreign
	Director		135-01-3095	1 □ M 2 ☑ F	96	Yrs.			11-19-1		Unkno	
	pug *		Usual Residence of Decedent 10a. State 10b. Count	,	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	faryli	ō	MD Montgo			y Chase						1 ☐ Yes 2 ☐ No
	28e-1	Director	10e. Street and Number				10f. Zip Code			10g Cit	tizen of What Co	untry?
	with Ba or	ā	4711 Cumberland				20815			-	ted States	•
	ns 23	era	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No		14. Race - Amer	
200	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28e-f show aumetic event, the Mudical Examiliner must be notified at	by Funeral	1 Never Married 2 Ma 3 XWidowed 4 Divorce	ried Armed For	ces? 2 No e		If Yes, specify Cubin	an, Mexican, Puèr Specify:	to Rican, etc.)		Black, White Specify:	White
5	2 hou	ted	15. Decede	nt's Education		16a. Dece	dent's Usual Occup	pation	11.	16b. K	(ind of Business/l	ndustry
Maryland 21215-0036	thin 7	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	life.	kind of work done DO NOT use retire	during most of wo d)	rking			
V	ygien er th	Con	12			Antique	s Dealer				tail Sales	
2		Be	17. Father's Name (First, Middle	Last)					me (First, Middle			
<u>X</u>	ould be filed within Mental Hygiene. Merked other than sette event, the Metter wetter than the setter event.	²	Ike Scher					Rebecca	Mary G			
20	12 sh h and 7 Is m	l i	19a. Informant's Name/Relation Robert Wenger - S				ng Address <i>(Street</i> Sumberland					
a,	1 and Healt am 2 ther		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of		Date		ocation - City or	
ē	ages nt of nt of t: If it	1	1 ☐ Burial 2 ☐ Cremation		State	cemetery, crei	natory or other pla crematory	1	30-2012		ls Church,	
baltimore,	artme orten Injury	-	' 4 ☐ Donation 5 ☐ Other (: 21. Signature of Funeral Service		ard Sage		2. Name and Addre					
n	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumetic as 200cg.		121-		are bago		91 Rockvil					
г	= 11		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that ca	aused the deat	h. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final		le Oemen							Onset and Death
	/Medical		disease or condition resulting in death)	a	or as a conseq							·
	Examiner		Sequentially list conditions	b								
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /	or as a conseq					_		
Š.	icate be executed physicien and s the burial-transit	al E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a conseq	derice or).						
00/00	physicate sthe	edical		d								
ממ	law requires that the death certificate been signed by the attending 2 should be detached for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		rth 2 🗌 Feta	Ideath 3	Ectopic pregnanc	ý			23d. Date of deli	very Day Year
;	at the de by the a tached	Physici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unkno	ant at time of d wn	leath 5	Other (specify)					
7	res that tigned by	/ Ph	Part II. Other significant condit	ons contributing to de	ath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
2	luires n sign ald be	d by	Atrial Fibrilation						1 🗀	Yes 2	⊠No 3 □ Pro	obably 4 \(Unknown
ecords,	tw require s been sig should b	Completed							24a. Was		24b. Were au	topsy findings available
	m _ m	шо							auto perfo	ormed?	death?	completion of cause of 2 No
VII	sician: The certificate rector, pag	a	25. Was case referred to medica	d				26. Place of De	ath (Check only o		10168	2010
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🕅 No	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA Oth		Home 5 ☐ Resi		6 ☐ Other (Spec	cify)
5	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pendi	28a. Date o	of Injury h, Day Year)	28b. Time o	f 28c. Injui Wor		28d. Describe			
2	uttandii death. ctor: A y the fu	catio	2 Accident invest	igation				Yes 2 No				
DIVISION	ire ire	ertification;	3 Suicide 6 Could 4 Homicide deter	nined 200. Place	of Injury - At h ig, etc. <i>(Specii</i>	ome, farm, sti ly)	eet, factory, office		28f. Location (City or To			ral Route Number,
1	To the Hospitel of within 24 hours elected to the Funeral D completely filled in	edical Ce	(Check only 2 Medical	ng Physician: To the Examiner: On the ba	best of my kno	owledge, deat	h occurred at the til	me, date and place	e, and due to the	cause(s	i) and manner as d place, and due	stated. to the cause(s)
	To the P within 24 To the F complete	Med	one) 29b. Signature and title of certific	and mann	er stated.		29c. Licens				ate signed (Montl	
	N W W			11/2/	0100	No						; ;
			1 homas		of don't /	232) (Time	D505:	34		TU-	-23-2012	
			30. Name and address of person Thomas Masterson,				,	Viroinia 21	2101			
	Sta	te	31. Date filed (Month, Day, Year	32. Re	egistrar's Signa	ature	,					
	Registr		NOV 0 1 2012	Burn	1. h	well						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Della Bernadette Whitehurst 2012 4:00 P.M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rock Spring Assisted Living Harford Forest Hill If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** Days Hours (Month, Day Year) 1932 Maryland 215-28-0885 Feb. **Director** 1 ☐ M 2**XX** 80 Usual Residence of Decedent show 10a. State 10c. City, Town or Location hours after death with the Maryland notified at 10d. Inside City Limits Director 28a-f 1 Yes 2XX No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò r items 23a or ner must be n Funeral 1812 Perryville Road 21903 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewoonce. 2 Martin T. McHale Della M. Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Bolchoz / Daughter 1812 Perryville Rd. Perryville, Maryland 21903 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. 20a. Method of Disposition 20c. Location - City or Town, State Nov. De 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Timonium, Maryland 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Service-BelAir <u> 3 Newport Drive Förest Hill,</u> Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ind stage demente disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Due to (or as a consequence of): for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>숙</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HBG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has completely filled in by the funeral director, page 2 performed 1 ☐ Yes À☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Assised examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Living 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Cartifying Nurse Practitioners To the best of my knowledge; Seath occurred at the time, date and place, and due to the cause(s) and my 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32255 CETTBER 26,20/2

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Mor

1,00 PM

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J w. mocohn

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 Mary R. Wyatt 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Jarrettsville 3912 Old Federal Hill Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Rocks 8. Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 215-34-7354 Director 1 □ M 2 🕱 F 74 April 17, 1938 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 28a-f Maryland Harford 1 Yes 2 X No Jarrettsville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21084 U.S.A. 3912 Old Federal Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: White Year or Dates. item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wiley Cicero Blevins Mary Ruth Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Arnold Wyatt (Spouse) 3912 Old Federal Hill Road, Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o X Burial 2 Cremation 3 Removal from State November 02, 4 Donation 5 Other (Specify) Jarrettsville Cemetery Jarrettsville, Maryland 2012 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive Forest Hill, Maryland 21050 Jeffrey R. Testernan (M01543) 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Dis Assecration. Onset and Death Immediate Cause (Final magnetic Flectro Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by alcomare Signer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗌 No 2 1 No Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 V No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Certifying Number Practitioners To the desidency making death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentifying Number Practitioners To the desidency investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S. Kaaquorap D 0023130 10/31/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tree Rd, Beleir, MD 2015

Registrar

31. Date filed (Month, Day, Year)

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barker

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Adoest Oliver Wood 7:00A M October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10082 Cabachion Court City Howard tllicott 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 216.20.626 MD Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21042 Funeral USA 10082 Cabachon Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Specify: African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed 3 Divorced Year or Dates 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Schools School Teacher 12tharade St Vears Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked
any injury or any 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert G. Wood Madeline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Almeta Wood (WIFE) Court Ellicott City MD 10062 Cabachon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greente Fureral Services au Kora Randallstown MD 21133 23a. Part 1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, sort or cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Immediate Cause Final Onset and Death Attorosclerolic Cerebero Vascular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by t d be detach Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has b director, page 2 s autopsy performed? 2 No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After Natural 5 \square Pending Accident within 24 hours after death

To the Funeral Director; A

completed filled in by the 1 Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) & Clanurd D3064 November 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabapath 201-109 Back River Mick Poad Ramesh 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 10:00P M VILLIAMS 20t /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 2004 Wisper Windsor Baltimore MIU Woods If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day 5. Social Security Numbe 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Windsor Mill Baltimore MD 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Woods Way by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Chemical Plant perator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be raymond Williams Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau b. Williams /WIFE Woods Way Windsor Mill MD Lorraine fimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dwims Mills, MD Garrison Forest 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3 C. Greeke Funeral Services G Jauahn 8728 Road Randallstown MD 21133 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of lying, such a shock, or heart tillure. List only one cause on each line. Approximate Interval Between Immediate Cause I inal **Physician** disease or condition resulting in death) /Medical Examiner as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underl in J Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Box 687605 and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the 9□Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Sunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has I page 2 autopsy performed? certificate 2□ No 1 1 🗆 Yes Division or Vital 2 □ No To the Hospital or Attending Physician: within 24 hours after death. director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of D 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Hallural 5 ☐ Pending investigation Injury n 24 hours after death.

ne Funeral Director: A
oletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Pt e of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

30. Name and address of person who completed cause of death (Item

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #196 State of Mary and Hepartment of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 25^{Day} Frederick 20Î2 Wilson 6:35am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Milford Manon Nursing Home
5. Social Security Number 6. Sex 17. Age Ilin vrs. Ja Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12 08 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 214-14-0034 Director 1 🛣 M 2 🗆 F 92 19 MD Usual Residence of Deceder in then "natural", or Items 23a or 28e-f show the Medical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5418 Clifton Ave 21207 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ 1 X Yes 2 □ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT userstired)
Regional Custodian 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City 12th grade Supervisor Be permit. Page 1 and 2 should be filed Department of Health and Mentel Hy Important: If item 27 is marked ottany injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sam Wilson Viola Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) 3608 Goydon Road, Baltimore, Md 21207 Adele White-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet 11/1/2012 Crownsville, Md Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 300 Wabash Baltimore, Md n. Pary 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Onset and Death Physician disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner ~~ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events resulting in death) Last Physician/Medical Chron adnus Diduse Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, 072536

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31. Date filed (Month, I

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SVMIT BNUTAN) 821 NENTON S- duty 308

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 8:51 John Francis Werner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 31177 McCormick Swamp Road Princess Anne Somerset . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Country) Director X M 2 D F 048-34-0660 69 07/08/1943 Connecticut Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Importent: If Item 27 is merked other than "netural", or items 23a or 28a-1 shown in Injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X☐ Yes 2☐ No MD Somerset Princess Anne 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 31177 McCormick Swamp Road 21853 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married > Married ☐ Yes 2√☐ No 1 ☐ Yes X☐ No Specify: If Yes, Give 3 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Pressman Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Werner Edna Levdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Gregory / Daughter 379 Snake Meadow Rd., Danielson, CT 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/24/2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CARCINDUNA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the deeth certificate be executed **To the Funerel Director:** After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use es the burial-transli that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy 1 Ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funerel Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed

32. Registrar's Signatur

33

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month haelEWalker 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore immonium If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) 34-0923 Director 1 3M 2 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Saltimore Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 09 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed unknown Paint Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown ochoper an Walker Marvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Cawthorn / Cousin Greenwood Avenue, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/30/2012 Anatomy Gifts Registry Hanover, Maryland 21. Sign sure of Funer Service Licel See 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or injuly that initiated events resulting in death) Last To the Hospital or Attending Physicien: The lew requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
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To the Funeral Director At completely filled in by the fu Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yea. NOV 0 1 2012 State Registrar

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			State Registrar			Cer	tificate of L	Death		Reg. No. 2	12	3487	7
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15			Mercedes Terre	· ilm -	4 C	amphe	ell Blvd	Suite	200 1	saltimore	2 2	1236	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 9:10 рΜ Rosalyn Barco Zitelman 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Geath 4c. County of Death Examiner Montgomery Rethesda 5225 Pooks Hill Road If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Director 263-34-9B05 84 1 DM 2 1X F Vrs Florida 9-24-1928 Usual Residence of Decedent 28a-f shov 10c. City. Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland Director MD Bethesda 1 Yes 2 □ No Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States Funeral #1501 20B14 5225 Pooks Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2X Married Ś Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fannie Miller Jack Barco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10433 Snow Point Drive, Bethesda, Maryland 20814 Michael Lichtenstein - Son in Law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State King David Memorial Gardens 10-31-2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Brad Smetzer 22. Name and Address of Facility Oanzansky-Goldberg Bud 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\subseteq \text{No.} \) 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 🛛 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Oate signed (Month, Day, Year) 10-29-2012 032407 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Haggerty, MO - Medical Center Orive,Rockville, Maryland 20B50 32. Registrar's ignatur State

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Registrar

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Director		579-09-28 Usual Residence	of Decedent 10b. County	1 M 2 □ F		Yrs.	Months	Days	Hours	Min.	(Month, Da		Was		DC
s 23a or 28a-f ust be notified	Funeral Director	MD 10e. Street and Nur 7702 Top	mber	George's ———— et	New	Carrol	10f. Zip	Code 0784					n of What Cou	•	□ No
, or	ام	11. Marital Status 1 ☐ Never Marr 3 ☒ Widowed		Armed For 1 ☐ Yes If Yes, Give Year or Dat	2 🔀 No	1	f Yes, spec	ify Cubar 2 🔼 No	Specify:	i, Puerto	cify Yes or No- Rican, etc.)		Race - Ameri Black, White, ecify: Whi	etc.	
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Departme Importan any injur		21. Signature of u	5 Other (Spec		TO FEE.	22	. Name and	d Address	s of Facilit	y For	-2012 t Linco Brento	oln Fu		Home	
hysician and the burial-transit	dical Examiner	23a. Part 1. Enter to shock, or heal Immediate Cause (disease or condition resulting in death) Sequentially list content in the cause (Disease or that initiated events resulting in death) I	nditions,	a. Due to (c	or as a consequence of as a consequence a consequence or as a consequence or as a consequence or as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence	ence of):	PIC	St	ocl	2	теврпасоту а	1651,		Approximate Interval Betwee Onset and Deat	
the attending p	~ I	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 🗀 Feta ant at time of d	death 3	Ectopic p		,			23d	d. Date of delive	very Day Year	r
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within 24 hd To the Fun completely	Medical	(Check 2 only one) 3	☐ Medical Exar ☐ Certifying Nu	ysician: To the be niner: On the basis rse Practitioner:	s of examination To the best of m	and/or invest y knowledge,	igation, in m death occu	rred at the	n, death oc e time, dat	ccurred at te and pla	the time, date oce, and due to	and place, and the cause(s) a	d due to the ca and manner as	ause(s) and manne stated.	er stated.
12		30. Name and address 143 Co.	es of person who	completed cause	of death (Item	23a) (Type, P	rint) De	24 NDEK	57 ((D)	× := :	10.	-9-12 D 2-8	2)))	
State		143C	h, Day, Year)	((A))	gistrar's Signatu	ure L	N,	IV	4	4) C	- LE	- 1/1			
Registrar		OCT 1 6	CUIZ A	energy by	9. 1941										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCtober 11, 2012 William Barron Boyd 12:50 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 251-14-4773 Director 1 🖾 M 2 🗆 F 91 Jan. 11, 1921 2 should be filed within 72 hours efter death with the Maryland thend Mental Hyglene. 27 is marked other than "natural", or items 23e or 28a-f show treumetic event, the Medical Examinar must be nutflied at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3118 Gracefield Road, Apt. 510 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. ≥ 1 Never Married 2 Married Specify White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Divorced Completed Year or Dates. WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Aerospace Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Barron Boyd, Jr. Mabel Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Baird Boyd/Wife 3118 Gracefield Road, #510, Silver Spring, MD 20910 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date unk 20c. Location - City or Town, State permit. Pege 1 e
Department of H
Important: If ite
any injury or ot Arlington National Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington, VA 21. Signature of Funeral Service Licenses Francis Adress Coritins Funeral Home Inc. mes 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracerebral Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial invertion, page 2 should be deteched for use as the buriet and Lagrana. resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 1 Yes 2 No ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Pragtitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 11+1 D36716 October 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Kundrat, MD 3110 Gracefield Road, Silver Spring, MD 20904

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

OCT

1 5 2012

Maryland 21215-0036

Baltimore.

68760

P.O.

Records,

Division of Vital

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Walter Stephen Booth A M October 0 2012 2:16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 9814 Rosensteel Avenue Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 149-40-1923 1 X M 2 □ F Yrs 62 05/29/1950 New Jersey Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9814 Rosensteel Avenue 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Important: If item 27 is marked other than eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) ttorney - Li<u>tigator</u> 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Stephen Booth Matilda Mary Nogi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen A. Booth / Spouse 9814 Rosensteel Avenue Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-15-2012 | Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons LLC. 21. Signature of Funeral 5130 Wisconsin Avenue NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final Onset and Death Metastatic Pancreatic Cancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should he detached. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 K Residence 6 \square Other (Specify) Certificate: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29d. Date signed (Month, Day, Year) D0070511 October 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lauren Mauro, M.D. 401 N. Broadway Suite 1363 Baltimore, MD 21231

State

Registrar

31. Date filed (Month, Day, Year)

OCT 15 2012

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4a. Facility Name (If not institution, give street and number) Data 11:30 1,2012 /Medical 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days 215-92-9679 50 12011962 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show 1 √Yes 2 No Director Easton traumatic event, the Medical Examiner must be notified Talbo 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2160 Funeral U.S Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "naturai" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Officer Detention Center tional **Baltimore**, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Grown Geneva Valter ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) taston, Naryland 21601
20c. Location City or Town, State Department of Health ar Important: If item 27 is any Injury or other trau-once. StandishStreet 69 oro wn Athena 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Paradise Cemetery 10/6/12 Trappe, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, 23a. P. 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as ardiac or respiratory arrest,

Approximate

Shock or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** Failure neart disease or condition resulting in death) /Medical a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760. Physician/Medical Interstitial Lung Disease IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 X\0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \square Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence P 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗀 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature a 29c. License number MD 7395 completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 State OCT 9 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001 11595

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			Registrar	Cen	tificate	e of D	eath			Reg. No.	2012	34883
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	Examin		4a. Facility Name (if not institution, give street and number)		4b. City,	Town, or	Location of	of Death			County of Death	1
ng di			Heartland of Hyattsville				ttsv			I	Prince (George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			nplace (State or Foreign entry)
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	Man 28a- notifie	Director	Maryland Prince George's				Нуа	ttsv	ille			1 🔀 Yes 2 □ No
	ith the	ral	10e. Street and Number 6500 Riggs Road		10f. Zip		0783		l	-	zen of What Cou nited St	
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E O	Page ment o tant; If jury or		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemeter, 4 ☐ Donation 5 ☐ Other (Specify) Mt. 01		atory or o			Oct.	012		shingto	
Baltimore,	permit. Page Department Important; It any injury or once.		21. Signature of Funeral Service Licensee				s of Facilit				al Home	
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Division of	s after Directory		4 Homicide determined 286. Place of Injury - At nome, far building, etc. (Specify)	1111, 50101	or, ractory	Onioc		ľ	City or Tow		Nulliber of hurs	ar noute Number,
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	- ≥ F ŏ		I ALL MD		250.		04786	7			e signed (Month,	
	19		30. Name address of person who completed cause of death (Item 23a) (T	Type, Pr	int)		.,,00	•		JELOE	/CI IU,	2012
	Ψ,		Oney Zuniga MD 4701 Randolph Rd.	#2		Rocky	ville	, Ma	ryland	208	52	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 34884 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 70/04\5075_{teal} Month Carolyn Brown 00:37 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 229-52-5925 Director 1 - M 2 X F 71 08/09/1941 VA Usual Residence of Decede 28e-f shov 10a, State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Prince Georges 1 X Yes 2 No Clinton 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9601 Dangerfield Rd. 20735 **AZU** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 5 ò 1 ☐ Yes 2 🛛 No If Yes, Give 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: "naturai", Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiane. Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Flooring Business Be 17. Father's Name (First, Middle, Last) should be file and Mental F rs marked of 18. Mother's Name (First, Middle, Maiden Surname) မ Ernest Simpson Frances Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Paga 1 and 2 sh Department of Health ar Important: If Itam 27 is any injury or other trau James A. Brown / husband 9601 Dangerfield Rd., Clinton, MD 20735 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 10/10/2012 4 ☐ Donation 5 ☐ Other (Specify) hesapeake Crematory Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Strickland Funeral Services <u>6500 Allentown Rd., Camp Springs, MD 20748</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one respiratory arrest, shock, or heart failure. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be datached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2: After this certificate has 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death, To the Funeral Director. After this certifica completely filled in by the funeral director, to **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident 2 🗌 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed raine of death (Item 23a) (Type, +Or r 31. Date filed (Month, Day, Year, State 6 2012 Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Î 2 October 5:10 AM M Charles N. Bettis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Kline Hospice House Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Director 011-30-2553 1 [XM 2 □ F Yrs. June 12, 1938 74 Maryland Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 1 Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 5 23a Funeral 21703 USA 6322 Towncrest Court "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No 1956—
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify 3 Widowed 4 Divorced 1958 White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of ဂ William Bettis Alice Ward permit, Page 1 and 2 should I Department of Health and Me Important: If item 27 is mar! 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christy Jones / Daughter 12716 Royal Carriage Dr., Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth ☐ Burial 2 XCremation 3 ☐ Removal from State 10/11/12 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused shock of heart failure. Ust only one cause of each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nset and Death Immediate Cause (Final Promiser in the disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine The to lor as a nonnectioned off: if any, leading to transcil cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Pregnant at time of death 2 No ed by the a Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy certificate ! 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice House 1 Inpatient 2 ER/Outpatient 3 DOA မြ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury ours after death.

leral Director: Aft
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an title of certifier

State

9+1

31. Date filed (Month,

Street Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kander MD

COLANG

egistrar's Signatu

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 6:30AM 2EI 10 09 - 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Heritage Harbour Health & Rehab. Ctr. Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 527-16-2987 1 XM 2 □ F 04/05/1920 0klahoma Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 Funeral 8801 Sandrope Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 🕅 Widowed 4 🗆 Divorced Year or Dates. Retired 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Army Master Sergeant Be 17. Father's Name (First, Middle, Last) Unk. 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine S. Hunt/Daughter Sandrope Court, Columbia, Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Qther (Specify 4 Donation 10/11/2012 | Edgewater, Maryland Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Examiner ENSION ERT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner brillatio and Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 24 hours after death.

Funeral Director: After this certificate is Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural injury 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) F.00 10-10-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAIGH MAHBOOB

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Mo

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3 Jime of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 2012 14, Murle Eugene Beeker 8:06 PM Oct. Medical Facility Name (if not institution, give street and number)
Dove House
Carroll County Hospic 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Westminster Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Hours 216-18-7208 1**%** M 2 □ F **Director** 88 May 12, 1924 Maryland Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location or then "naturel", or items 23e or 28a-f sho Director 1 Yes 2 No Baltimore MD Parkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 18214 Foreston Road 21120 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married ۾ within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Car Dealer Auto Mechanic Be permit. Page 1 end 2 should be filed.
Department of Health and Mental Himportant: If item 27 is meny injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura C. Wood Murle R. Beeker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18214 Foreston Rd. Parkton, MD 21120 Mary F. Lang 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct.Date 22, 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Middletown Cem. 2012 Freeland, ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JJ Hartenstein Mortuary, 21. Signature of Funeral Service Second St. New Freedom, PA 17349 24 N. 23a. Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use es the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No After this certificate 1 🔲 Yes 1 | Ves director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 1 Yes 2 ☐ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 filled in by the funeral 24 hours after death. Funeral Director: A

Baltimore, Maryland 21215-0036

Medical within 24 hours to the sound to 0 0 State

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Contributing Nurse Procurrence: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionner: To the best of my knowled up, death occurred at the time, date and clace and due to the causals and manner as stated and title of certifier 29d. Date signed (Month, Day, Year) License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) NGV 0 1 2012 32. Registrar's Signature

6 Could not be

determined

3 Suicide

29a. Certifier

29b. Signatur

(Check

anly ar

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ctober Physician/ BITNER HARDING 110 M WARREN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Meritus Medical Center Hagerstown Washington 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 201-09-1423 Director 1**X**□ M 2 □ F 91 Dec. 20, 1920 Pennsylvania Usual Residence of Dece or 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Md. Washington 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 10334 Mapleville Rd. 21740 U.S.A items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Specify: Year or Dates. 42 - 4616a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Pension Consultant Finance 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Charles Bitner Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10334 Mapleville Rd. Hagerstown, Md. 21740 Peggy J. Bitner (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. Smithsburg Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. M01414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Physician. disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death the 1 ☐ Yes ∠ ☐ Unknown Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy (3) 8 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nonpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this (completely filled in by the funeral dil 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20069606 DCTOBER

Registrar

State

#103. Hagerstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD

32. Registrar's

North

Blvd

Eastern

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 1:30 Irene Wuensch Coggins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days Hours (Month, Day, Year) 090-50-3529 Director 1 - M 2 T F 53 April 7, 1959 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It was 23 or 28a or 28a-f show then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10104 Lakestone Place 20850 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. White ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Advertising Product Marketing æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marlene Koelschtzky Bruno Wuensch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10104 Lakestone Place, Rockville, MD 20850 Patrick Coggins/Husband : If item 2 or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. 19, cemetery, crematory or other place) 1 Burial 25 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Rectosi moid Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed? Yes 2 🖾 completely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: HOSPICe
4 Nursing Home 5 Residence 6 X Other Specify) 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 6 2012

Bindu Joseph, MD

31. Date filed (Month, Day, Year,

D60634

6001 Muncaster Mill Road, Rockville, MD 20855

Oct. 14, 2012

			For State	State of Ma	-	epartmei <i>Certificat</i>			vientai Hy	-	010	0:001
			Registrar 1. Decedent's Name (First, Middle, Las	t)		eruncai	e or De	aui	2. Date of De	Reg. No.	0 + 2	3. Time of Death
	Physicia		Dehong	~ Ch	11				Month Octobe	Day	2^{Year}_{012}	9:30 P.M
1	Medic Examin		4a. Facility Name (if not institution, give		<u> </u>	4b. City	, Town, or Lo	cation of Death			nty of Death	1 3 . 30 1 .
			174 Gold Kettle D	rive			aithe	rsburg		Me	ontgome	ery
1	Funeral		5. Social Security Number 6. Se		(In yrs. last birthda	y) If Under		Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthp Coun	place (State or Foreign
	Director		417 17 1010	X M 2 □ F	77 Yrs		,		10/08			ina
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location			10/00	1 1 200		0d. Inside City Limits
	laryla 3a-f s ified	ect	Maryland Montgo	merv	Caith	ersbur	O'					1 🛣 Yes 2 □ No
	or 28	اقا	10e. Street and Number	inc1)	Gartin		p Code			10g. Citizen	of What Cour	itry?
	with s 23a ust b	Funeral Director	174 Gold Kettle D	rive			20878			Ch	ina	
	death item: ner m	Fun	11. Marital Status	12. Was Decedent E		3. Was Dece	dent of Hispa cify Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
36	after ", or kamir	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 1 If Yes, Give	No		2 X No 5		,	Spe	rify	
8	atura cal E	Completed	15. Decedent's Ed	Year or Dates.	16a D	ecedent's Usu	ial Occupatio	on		16h Kind o	AS:	ian
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212	withir giene er th	ပ္သိ	8	College (1-4 of 3-	7	Worker	=	_		Gr	ain Fa	ctory
nd	filed tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)				18	8. Mother's Nan	ne (First, Middle	, Maiden Surn	ame)	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	۲	· · · · · · · · · · · · · · · · · · ·	i Chu					Liu	Shi	Chum	
Mai	shoo h and 7 is n traum		19a. Informant's Name/Relationship (T)	vpe, Print)		•			al Route Numbe		•	
e,	and 2 Healt em 2	1	Hong Fa Chu/Son 20a. Method of Disposition		20b, Place of D			y, Rock	ville,		on - City or To	
nor	age 1 ant of tt: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemetery,	crematory or	other place)	10/1			,	
Baltimore,	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau	-	Johnstion 5 Li Other (Specification) ture of Funeral Service Licens		Gate of				Vol Fune			ng, Maryland
Ä	Dep Imp any		> Wedage	Ch le	Iller							D. 20877
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	olications that caused	the death. Do not							Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	Chronic	0bstruct	ive Pu	lmonar	ry Disea	ase			Onset and Death
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		er	Sequentially list conditions,	b. Due to for so a	consequence of):						_	
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0	Attending Physician: The law requires that the death certificate be executed redeath or redeath. **redeath.** **redeath.* **redeath.** **r	edical Examiner		d								
68760	tificat ng ph as th		IF FEMALE:									
9 ×	th cer tendii	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth	2 🗌 Fetal death	3 Ectopic				23d.	Date of delive	ery Dav Year
Box	e deat the at hed fo	ysic	1 Yes 2 No	4 ∐ Pregnant at 9 ☐ Unknown	time of death	5 U Other (s	pecify)				MOULL	Day rear
P.O.	ed by detac	/ Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in t	he underlying	cause given	in Part I.	23e. Did	tobacco use c	ontribute to the	ne cause of death?
S, F	ires the signer	Completed by Physician/M	Non Small Cell Ca	rcinoma of	the Lur	ıg			1 🖾	Yes 2 N	lo 3 🗆 Prol	oably 4 🗆 Unknown
ord	requipeer shou	lete							24a. Was		lb. Were auto	psy findings available
ec	ysician: The law is certificate has director, page 2	omp							auto	opsy ormed? 2 X No	prior to co death? 1 \square Yes	mpletion of cause of
a H	ician: The certificate rector, pag	Be C	25. Was case referred to medical				26. Place	of Death (Chec		2 LAS NO	i 🗆 res	2 🗆 100
Vit.	Physici this cer ral direc	To E	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 🗌 Inpatie	nt 2 ER/Outp	atient 3 🗆 🗆	Other:	4 Nursing H	ome 5 🗷 Res	idence 6 🗆	Other (Specify)
of	ding Phy h. After thii funeral		27. Manner of Death 1 Matural 5 □ Pending	28a. Date of injur (Month, Day	y 28b. Tim Year) inju		28c. Injury at work?		28d. Describe	how injury occ	curred	
ion	tendi leath. tor: A the fu	ifice	2 Accident Investigation 3 Suicide 6 Could not b			М	_	s 2 🗆 No				
Division of Vital Records,	or At after c Direct in by	Certificate:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm (Spec <i>ify)</i>	, street, facto	ry, office			Street and Nu wn, State)	mber or Rurai	Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 X Certifying Phys	sician: To the best of	my knowledge, de	ath occurred	at the time, d	ate and place.	and due to the d	ause(s) and m	anner as stat	ed.
	n 24 h	Medical	(Check 2 Medical Exami		amination and/or in	vestigation, in	my opinion,	death occurred a	at the time, date	and place, and	due to the ca	use(s) and manner stated.
	Within Within		29b. Signature and title of certifier	100	MAS	29	c. License nu	umber		29d. Date sig	gned (Month,	Day, Year)
	ta .		Nanut H X	Mand	MD		D 555	522		Octobe	r 11,	2012
			30. Name and address of person who	-			•					
			Robert H. Gerard, 31. Date filed (Month, Day, Year)			Glen	Road,	Silver	Spring	, Maryl	and 20	910
	Sta Registra		OCT 12 2012	2. Registra	r's Signature	whole						

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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		For State	State of M	arylan		artment of He tificate of D		, ,	0	0.1.2	31,892
	_	Registrar 1. Decedent's Name (First, Middle, La.	st)		Cer	uncate of D	eauri	2. Date of Deat	Reg. No.	UIL	3. Time of Death
Physicia		Lily Y. Chang	5.9					October)12 ^{Year}	6:00 AM
Medio Examin		4a. Facility Name (if not institution, give	e street and number)			4b. City, Town, or L	ocation of Death	100000		ty of Death	1 0000
		619 Goldsborough	Drive			Rockvil	le		Mont	gomer	У
Funeral Director		0 - 1 10 1 1	Sex	e (In yrs. la	ost birthday) 00 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 8,	1922	g. Birth Coun Chin	place (State or Foreign try) I.a.
nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits
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the N or 28	Ē	10e. Street and Number	D .			10f. Zip Code			10g. Citizen o	f What Cour	ntry?
n with	Funeral	619 Goldsborough	Drive			20850			United	1 Stat	es
death r item iner n		11. Marital Status	12. Was Decedent E Armed Forces		S. 13. V	Vas Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.			Daughter)			Autumn Oa					
je 1 ar t of Hi If iter or oth		20a. Method of Disposition 1 Durial 2 Stremation 3	Removal from State	20b. F	Place of Dispo	sition (Name of natory or other place OIItan latory	Octo	ber 11,	20c. Location	n - City or To	own, State
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permit Depar Impor any in once.		21. Signature of Funexal Service Licen		10068		Name and Address O E. Deer					MD 20877
		23a. Pag 1. Enter the disease, or com	plications that caused	the deat						Juig	Approximate
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Medical		disease or condition resulting in death)	a. Cholang Due to (or as			ma				-	
Examiner	L	Sequentially list conditions	h								
T #0	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):						
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physis the	ledi		d								
certif anding use a	J/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			Ectopic pregnancy			23d, [Date of deliv	ery
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of the		9 Unknown Part II. Other significant conditions of		ut not res	ulting in the u	nderlying cause give	en in Part I	23a Did tob	hacco use co	ntribute to t	ne cause of death?
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ysicia is cer direct	To B	examiner? 1 ☐ Yes 2 🎛 No	Hospital:	ent 2 🗆	ER/Outpatier	_ Other		ome 5 🖾 Reside	ence 6 \square O	ther (Specify	·)
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia. To make the funeral director, page 2 should be detached for use as the bur	Medical	(Check 2 Medical Exam	rsician: To the best of hiner: On the basis of e se Practioner: To the	xamination	n and/or invest	tigation, in my opinion	, death occurred a	t the time, date an	nd place, and o	due to the ca	use(s) and manner stated.
The property of the property o		29b. Signature and title of certifer				29c. License			29d. Date sign	·	
		30, Name and address of person who	completed cause of d	eath (Item	23a) (Timo F	D005	2864		Octobe	L 9, 2	.014
		Kevin P. Collier	. M.D 10)215	Fernwo	od Road,	Suite #4	04, Beth	nesda,	Mary1	and 20817
Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signa	ture 1	4.1					
Registra H 17 Rev 7/20		OCT 12 20	16 Chaus	ع ر	. pa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Coleman October 3, 2012 Mattie 7:20 a м 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health & Rehab. Ctr. Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 12/10/1921 579-12-2721 90 1 🗆 M 2 🎽 F S. C. 10b. County 10c. City, Town or Location 10d. Inside City Limits D. C. none Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 U.S.A. 1015 Webster Street, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Private Elementary/Secondary (0-12) College (1-4 or 5+) Medical Records Librarian Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bud McManus Ida Mae Walker 19b. Mailing Address (Street and Number or Rural Route Number Wash Ingle Cincole) DC 20011 19a. Informant's Name/Relationship (Ty/Darighter Ida Elaine Clark

10/10/12

20c. Location - City or Town, State
Washington, DC

29d. Date signed (Month, Day, Year)

10/8/12

Rockville 20850

Physician/ Medical

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

1 - State Registra

10a. State

Director

Funeral

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Completed

Be

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20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State

21. Signature of Funeral Service Li en ee CC 0 5 3 0

4 ☐ Donation 5 ☐ Other (Specify)

Physician/

Medical

Examiner

Funeral

Director

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneal director, page 2 should be detached for use as the burnal director.

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

OCT

Truong Bao, M.D.

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Sev, 1900)

Division of Vital Records, P.O. Box 68760

	21. Signature of Funeral Service Liver et	CC0530 22 Name Liate 383:	e and Address of Facility ney's Funera I Georgia Av	al Home e, NW Washingt	on, DC 2001
9: 7:	23a. Part 1. Enter the disease, or compt shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	eations that caused the death. Do not enter the ne cause on each line. Low Gos TuvE Due to (or as a consequence of):	3 3		Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
ıysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Who 9 □ Unknown	3c. If yes, outcome of pregnancy 1	oic pregnancy r (specify)	23d. Date of Month	delivery Day Year
ted by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 MANo 3 ☐	e to the cause of death? Probably 4 □ Unknown
Complet				autopsy prior performed? death	autopsy findings available to completion of cause of 1? Yes 2 No
Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death (Chec.	k only one)	
6	I LI Yes 2 7 No	1 Inpatient 2 ER/Outpatient 3		ome 5 Residence 6 Other (Sp	pecify)
ficate:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred	
Certi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	tory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
Medical Certificate: To	(Check 2 Medical Examine	ician: To the best of my knowledge, death occurre er: On the basis of examination and/or investigation, Practitioner: To the best of my knowledge, death	, in my opinion, death occurred a	at the time, date and place, and due to t	he cause(s) and manner stated.

29c. License number

00057124

20b. Place of Disposition (Name of

Rock

cemetery, crematory or other place)
ock Creek
Cemetery

DHMH 17 Rev 06-2011

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, M.D. 10110 Molecular Dr., Suite 206

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Physician/ Katherine J. Christopher 2012 12:34 PM October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Denton Caroline Caroline Nursing Home 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** Min. Months Hours 1 M 2 XF 214-68-7455 Director 57 10 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director Federalsburg Caroline 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 21632 Funeral items 23a 105 Greenridge Road United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 X No 5 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White "natural", 3 🗌 Widowed 4 🔲 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Child Care Nanny Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Mae Inscho ည William Marlin Evey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Greenridge Road, Federalsburg, MD 21632 Keith Christopher/ Spouse Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Cambridge, Maryland 10/17/12 4 Donation 5 Other (Specify) Mid Shore Cremation 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records. 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 27. Manue of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 - Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20053255 10/16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Plank Rd Preston MD 21655

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

3683

am

Registrar's Signature

			For State Registrar	State of	Maryland		artment of F rtificate of			F	Reg. No.	012		
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)						Date of Dea Month	Day	Year	3. Time of E	Death
	Physici /Medic		Shari M.	Craig					`	10		2012	4:10P	M
1	Examin		4a. Facility Name (If not institution	-	-		4b. City, Town, o					ounty of Death		
And S			Arcola Health a				Silver					ntgomer		
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. las		If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birtl Month, Day	h v, <i>Year)</i>	9. Birthp	olace (State or ntry) NY	Foreign
н	Director		055-48-1787	10 W 25A	30	Yrs.			0	3/02/	1954		NI	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation			.,		1	0d. Inside City	/ Limits
	laryla sho	ō											1 X Yes .	2 🗌 No
	he N	ect	MD Prince	George's	G	reent	10f. Zip Code				10a. Citizer	n of What Cour	ntrv?	
	with	Funeral Director		D			20770				USA		,	
	sath y	eral	7986 Lakecrest	12. Was Decede	ont Ever in II S	12		lispanic Oric	nin? (Specify	Yes or No-		. Race - Americ	can Indian.	
	er de item	Ë	 Marital Status Married 2 ☐ Marr 	Armed Force	es?	13.	Was Decedent of H If Yes, specify Cuba	an, Mexican	, Puerto Rica	in, etc.)	' '	Black, White,		
36	rs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1∐Yes 2⊠No	Specify:			St	pecify: Bla	ack	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show lical Evan iner mat be multified at	ed	15. Decedent			16a. Dece	dent's Usual Occup	oation			16b. Kind	of Business/In	dustry	
15	in 72 n "na	Completed	(Specify only highes	st grade completed) College (1-4	or E . \	(Give life.	kind of work done DO NOT use retire	during most d)	of working					
2121	with jiene r tha	E	Elementary/Secondary (0-12)	College (1-4	S S	BA Po	rtfolio	Manage	er		Bank	ing		
p	filed If Hyg othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (Fi	rst, Middle,	Maiden Su	ırname)		
Maryland	2 should be filed within on and Mental Hygiene. is marked other than "raumatic event, In Men	To B	Robert Wi	lliams				Hen	rietta		Craig	5		
<u> </u>	shound N		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailii	ng Address (Street	and Numbe	er or Rural Ro	oute Numbe	er, City or T	own, State, Zij	o Code)	
Ξ	nd 2 alth a 27 is 27 is		Michael Anthony	Ross/Son		7986	Lakecres	t Dri	ve Gre	enbel	t, MD	20770		
ē,	s 1 a of He item othe	l	20a. Method of Disposition	_	20b. Plac	ce of Dispo	sition (Name of natory or other place	ce)	Date		20c. Loca	tion - City or To	own, State	
Ë	Page nent c nt: if		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate		Cemetery	i	0/13/2	012	Lind	len, Ne	w Jerse	:y
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Evander of ust be notified at once.		21. Signature of Fune al Service		/		2. Name and Addre			All and the second second	arch	Funera.	1 Home	-
m	permi Depa Impo any ir		May TC.	ndeen 1	20/0.5	7	4217 9th	St. N	W Wa	shing	ton,	DC 200	11	
			23a. Part 1. Enter the disease, or	complications that cau	sed the death.	Do not en	ter the mode of dyi	ng, such as	cardiac or re	spiratory ar	rest,		Approximate Interval Betw	veen
	Physician		Shock, or heart failure. List Immediate Cause (Final	only one cause on eac	n line.	n 1	Cancer	-					Onset and D	eath
	/Medical		disease or condition resulting in death)	a. Due to (or	as a conseque									
	Examiner				C									
		ē	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	Due to (or	as a conseque	nce of):								
	cuted d ansit	Examiner	Cause (Disease or injury									1		
ó	execan arrial-tr	Exe	resulting in death) Last	Due to (or	as a conseque	nce of):								
3760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ical		d										
3	leath certifica attending ph I for use as th	ledi		1										
Box	h cer endir use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnand th 2 🗆 Fetal d		☐ Ectopic pregnanc	01/			23	d. Date of deliv		
	deat e attr	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of dea		Other (specify)					Month	Day Y	ear
P.0	ding Physiclan: The law requires that the de h. h. After this certificate has been signed by the funeral director, page 2 should be detached	Physician/Med	9 🗆 Unknown	9 LI UNKNO	VII									
	ss tha	by P	Part II. Other significant condition	ons contributing to dea	th but not resulti	ing in the u	nderlying cause giv	ven in Part I.				contribute to	- 20	
Records,	en si									1 🗆 \	Yes 2□	No 3 ☐ Pro	bably 4 🗗	Inknown
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ď	The I	E								perfo	rmed?	death?	2 440	
Vital	an; rtifica tor, p	BeC	25. Was case referred to medical					26. Place	of Death (C			121100		
>	ysicl is cel		examiner? 1 ☐ Yes 2 ♠ No	Hospital: 1 ☐ !n	oatient 2 ☐ El	R/Outpatie	nt 3 DOA Oth	ner: 4 🗎 Nu	rsing Home	5 Resid	dence 6 [☐Other (Spec	ify)	
Jou	g Ph ter th	ا قا	27. Manner of Death	28a. Date of	Injury 2 Day, Year)	8b. Time o	f 28c. Inju	ry at	28d	. Describe l	how injury o	occurred		
Division	Attending Ir death. ector: After by the funer	aţio	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	9 '	Day, rear)	ii ijai y		Yes 2□I	No					
<u>Vis</u>	or Attendi after death. Director: /	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 28e. Place 0	f Injury - At hom	e, farm, st	reet, factory, office		28f.	Location (:	Street and	Number or Ru	ral Route Numi	ber,
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification: To		g Physician: To the b)
	he H in 24 he F	edi	one)	and manne										
	Veith To t	Σ	29b. Signature and title of certified	8-		VA		se number	1174			signed (Month		
	5		(Contest	0		9		0069	OLT		10	- 06-	2012	
	0 -		30. Name and address of person		of death (Item 2	23a) (Type,	Print) R	~ / 11. /	4121		1 1	2 4 0	C=	
	ÆL.		SANDEEP SHA	, -, [//			DR. K	OCKV.	Het	· / N	(D)	0080	J ()	
	Sta		31. Date filed (Month, Day, Year)	32. Res	jistrar's Signatu									
	Registr	ar	OCT 1 5 2012	Change	B. 190	West of								
DI	MI 147 Day 1/0	201		/	-4									

DHMH 17 Rev 1/2001

			State of Maryland / De			nd Mental H	ygiene	012	34896
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of <u>E</u>	Jeath	2. Date of I	Reg. No.	UIL	
	Physicia Medic		Rose Marie Chambers			0ctob		201°2	3. Time of Death 9:16 A M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or				unty of Death	
a da			3705 37th Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Cottage	City If Under 24			ce Geo	
	Funeral Director		17/ /6 5007	Months Days		Min. (Month,	Day, Year)	Coun	llace (State or Foreign try)
	D WO	L	Usual Residence of Decedent			9/1	7/1954	PA	
	arylanda-f sh fied a	cto	, , , , , , , , , , , , , , , , , , , ,					1	0d. Inside City Limits 1 X Yes 2 \(\text{No} \)
	he Ma or 28a	Dire	10e. Street and Number	tage City			10g. Citizen	of What Coun	
	with 1 s 23a ust b	eral	3705 37th Ave.	20	722			USA	
	death ritem nerm	Fur	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hi If Yes, specify Cuba	spanic Origin n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	D- 14.	Race - Americ Black, White,	
336	al", or	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No	Specify:			cify: Blac	
Č	hours 'natur dical	olete	15. Decedent's Education 16a. Dec	edent's Usual Occupa re kind of work done d		fuarkina	16b. Kind	of Business/Inc	dustry
21	hin 72 ne. than "	omi	Elementary/Secondary (0-12) College (1-4 or 5+) life.	DO NOT use retired)				e Geor	
2	ed wit Hygier other	Be C	17. Father's Name (First, Middle, Last)	<u>inistrati</u> v		istance s Name (First, Midd.		y Gove	rnment
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	임	Walter Chambers				msley	arricy	
ary	of Health and Ment of Health and Ment fitem 27 is marked rother traumatic er	1		iling Address (Street a	and Number o	or Rural Route Num	ber, City or Tow	n, State, Zip C	Code)
	and 2: lealth em 27 her tr			Evergreen	n Rd I			17109	
Baltimore,	Page 1 annent of Hant of Hant of Hant of Hant If ite		20a. Method of Disposition 1 ☐ Burial 2 ত Cremation 3 😿 Removal from State 20b. Place of Disposition cernetery, cr	position (Name of rematory or other place ryland n Center	e)	Date		ion - City or To	wn, State
Itin	permit. Page Department o Important: If any injury or once,	- 0	4 Donation 5 Other (Specify) Crematio 21. Signature of Fungral Service Licensee	n Center 22. Name and Addres	i 1 (0/13/2012 Fort Line			Ome
ñ	Dep Imp any		Distathancis	3401 Blade					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failule. List only one cause on each line.	nter the mode of dying	g, such as ca	irdiac or respiratory	arrest,		Approximate Interval Between
	Medical	y. y	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Art	eriosclero	tic C:	ardiovasc	ular Di	sease	Onset and Death
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	cuted ind transit	Examiner	Cause (Disease or injury that initiated events c.						
	oe e iciar buri	dical E	resulting in death) Last Due to (or as a consequence of):						
760	certificate k nding phys use as the	a l	d						
200	n certif	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnanc	·v		23d	. Date of delive	ery
ğ	death	/sici	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)	,			Month	Day Year
л Э	w requires that the death certifica so been signed by the attending p 2 should be detached for use as t	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ren in Part I.	23e. Dio	tobacco use o	ontribute to th	e cause of death?
S,	n sign	ed by				1 [Yes 2 N	lo 3 🗆 Prot	oably 4🛣 Unknown
Vital Records,	iw req is bee 2 shoi	Completed				24a. Wa	s an 2		psy findings available impletion of cause of
ř	The la	Com				pe	formed?	death?	
<u>ra</u>	ician: certific rector,	Be	25. Was case referred to medical examiner? Hospital:	Otho		(Check only one)			
OT V	Physer this eral di	e: 10	1 🔀 Yes 2 🗆 No 1 🗀 Inpatient 2 🗀 ER/Outpati 27. Manner of Death 28a. Date of injury 28b. Time	of 28c, Injury	4 ∐ Nurs	sing Home 5 🛣 Re	sidence 6 🗌		·
ono	arth. rr: Afte	icat	1 Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation	work'	? Yes 2□N				
UIVISION	or Atte fter de irecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office			(Street and Nu	mber or Rural	Route Number,
5	spital o		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, deat	h occurred at the time	date and at	0		anner ac etet	ad.
	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	(Check only one) 3 Decertifying Practitioner: To the best of my knowledge, death only one) 3 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 3 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 3 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 3 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 3 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 4 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 5 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 5 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 5 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 5 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 6 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 6 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 7 Decertifying Nurse Practitioner: To the best of my knowledge, death only one) 7 Decertifying Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best of my knowledge Nurse Practitioner: To the best One	estigation, in my opinio	n, death occu	urred at the time, date	and place, and	due to the cau	ise(s) and manner stated.
	To th To th COME	-	29b. Signature and title of certifier	29c. License	number		1	gned (Month, L	Day, Year)
			1 Church		727	215	jo	10	2012
	Ism		30. Name and address of person who completed cause of death (Item 23a) (Type	,	Tono Asia		20701	(
773	Stat	e	Chinma Njoku, C.R.N.P. 5804 Baltim 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ore Ave E	<u>iyatts</u>	ville, Md	20781		
	Registra		OCT 1 2 2012 Senger B. gar	W.					

State Registrar Theodore L.

323 15th St., N.E.

Washington, D.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Watkins, M.D.

			For State State Registrar	-	artment of Health and I tificate of Death	Mental Hygien Reg. N	7017 34930					
ı	Physicia	n/	Decedent's Name (First, Middle, Last)			2. Date of Death	3, Time of Death					
	Medic Examin	al	SOLON CARROLL JR. 4a. Facility Name (if not institution, give street and n	umber)	4b. City, Town, or Location of Death	10-5-2012	2 10:44 A ^M					
	LAAIIIII		9410 SHIELD DRIVE		UPPER MARLBORO		PG					
h	Funeral Director		5. Social Security Number 051-40-9079 Usual Residence of Decedent	7. Age (In yrs. last birthday) 65 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year, 12–9–1946	9. Birthplace (State or Foreign Country) NC					
	yland f show ed at	ctor	10a. State 10b. County MD PG	10c. City, Town or Loc UPPER MARI			10d. Inside City Limits 1 Yes 2 □ No					
	he Mar or 28a		10e. Street and Number	OTT BIC TAIRC	10f. Zip Code	10g. (Citizen of What Country?					
	is 23a rust be	Funeral	9410 SHIELD DRIVE		20772		US					
036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	by	1 Never Married 2 Married 1 X Ye	Forces?	Vas Decedent of Hispanic Orlgin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK					
Baltimore, Maryland 21215-0036	2 should be filed within 72 hour h and Mental Hygiene. 7 is marked other than "natu traumatic event, the Medical	Completed	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College 2	ed) (Give h (1-4 or 5+) life. Do	lent's Usual Occupation kind of work done during most of work O NOT use retired) LITY MANAGER	king	Kind of Business/Industry OVERNMENT					
nd 2	filed wi al Hygie d other vent, t	Be	17. Father's Name (First, Middle, Last)	TACII		ne (First, Middle, Maide						
rylaı	uuld be d Menta markec matic e	P SOLON CARROLL SR. RACHEL OUTLAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta										
, Ma	d 2 sho alth an 1 27 is er traur		MD 20772									
imore	permit. Page 1 and 2 sh Department of Health a Important. If item 27 is any injury or other trau		20a. Method of Disposition 1 IX Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	l CEMETERY -	VETERANS 10-19	9-12 CHE	Location - City or Town, State					
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	22	Name and Address of Facility POI 538 MARLBORO PIKI							
I.	Medical Examiner					or respiratory arrest,	Approximate Interval Between Onset and Death					
	te be executed nysician and he burial-transit	sal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	to (or as a consequence of): to (or as a consequence of):								
. Box 68760	th certifica trending pl or use as t		in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
ls, P.O.	uires that the deat n signed by the at uld be detached fi	þ	Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death? 2X No 3 Probably 4 Unknown					
Division of Vital Records,	The law require cate has been si page 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 ☒ No					
ita	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? ¹X Yes 2 □ No Hospital:		26. Place of Death (Chec		a 🗔 au - (2)					
of \	ng Phys ter this ineral di	te: To	27. Manner of Death 28a. Da	□ Inpatient 2 □ ER/Outpatier ate of injury onth, Day, Year) □ Inpatient 2 □ ER/Outpatier 28b. Time of injury	28c. Injury at work?	ome 5 🛭 Residence 28d. Describe how inj						
ivision	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homiside determined	ace of Injury - At home, farm, stre ilding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)					
Δ	To the Hospital within 24 hours To the Funeral I completely filled	Medical	(Check 2 Medical Examiner: On the	basis of examination and/or invest	occurred at the time, date and place, igation, in my opinion, death occurred death occurred at the time, date and p	at the time, date and pla	ce, and due to the cause(s) and manner stated.					
		<	29b. Signature and title of certifier	Therest	29c. License number M 7 3 2 4 3 4	29d. [Date signed (Month, Day, Year)					
	JA		30. Name and address of person who completed c									
	Stat Registra	te ar	isk a n pastitetti let	O 2ND STREET. No. Registrar's Signature	NE, WASHINGTON, D	C 20002						
			STATE OF									

		For State Registrar	riea	State of			d / Depa		t of ⊢	lealth a		lental Hy		2 A	12	34	899
Physicia		1. Decedent's Nam Robert I		Last) Cavanaug	gh							2. Date of De	ath	, 2	012	3. Time of 1:19	Death A M
Medic Examin		4a. Facility Name (if Kline Ho			mber)				Town, or	Location o	of Death				of Death		
Funeral Director		5. Social Security N 485-50-7	umber 550	6. Sex 1 M 2 □ F	7. Age (st birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Feb. 5	h			lace (State o	or Foreign
iryland I-f show ied at	ctor	Usual Residence of 10a. State MD	of Decedent 10b. County Freder	ick	1		, Town or Lo								10	Od. Inside C	ity Limits
ith the Me 23a or 28a st be notii	Funeral Director	10e. Street and Nur 103 Tob	nber					10f. Zip	Code 1769			Ī	_		What Count	try?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be notified at once.	ed by Fune	11. Marital Status 1 Never Marr 3 Widowed	ied 2 🗆 Marri	12 Was Dec	orces?	0	'	Was Deced	ent of Hi	n, Mexicar	i, Puerto I	cify Yes or No- Rican, etc.)	1	14. Race Black	e - America k, White, e White	an Indian, tc.	
vithin 72 hour jiene. er then "natu ir e Merke.	Completed by	(Spe		's Education t grade completed College ()	16a. Deced (Give life. D Teac	kind of wo O NOT use	k done a		t of worki	ng		nd of Bu	isiness/Ind	lustry	
d be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (Romuald	First, Middle, La Cavana	ugh						18. Moth	er's Name e Dus	(First, Middle, sterhof	Maiden S t	urname)		
nd 2 shoul ealth and I m 27 is ma		19a. Informant's Na Bill Sau	ser (P	_{p (Type, Print)} ersonal l	Rep.)		-	*			Route Numberlerick,				ode)	
Page 1 a training the tant: If ite jury or oth				3 ☐ Removal from	n State	Chr	lace of Dispo emetery, crer LST K6	Torme	ther placed Ce		10/1	5/2012	Mid	llet	City or To	MD	
permit Depart Impor any in		21. Signature of Fu	n De	iorer.		MO1	612	Name ar Ceeney .06 E	d Addres Chi	s of Facilit Basfo Irch	řd P.	A. Fun Freder	eral ick,	HB ^m	21701	L	
Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List or Final	a. ###	ach line.	CEL	WA					r respiratory ar	rest,		/	Approximate Interval Bet Onset and	ween Death
ed nsit	miner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	rlying E	b. Due to	(or as a	consequ	ence of):									-	
ate be executed bhysician and the burial-transit	dical Examiner	that initiated event resulting in death)		c. Due to	(or as a	consequ	ence of):										
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, ou 1 ☐ Live 4 ☐ Pre	Birth 2 gnantatt	☐ Feta	Ideath 3	☐ Ectopic ☐ Other (s _f		у			2	23d. Dat Mo	te of delive	*	Year
ulres that to n signed by uld be deta	þ	Part II. Other signif	ficant condition	ns contributing to	death but	t not resi	ulting in the u	underlying	cause giv	en in Part	i.		obacco us	1		e cause of c	
The law req ate has bee bage 2 sho	Completed										_			p	Were autoporior to cor leath?	sy findings inpletion of c	available cause of
ilan:] artifica ctor, p	Be	25. Was case referrence examiner?	ed to medical						26. Pl	ace of Dea	th (Check		2/2/110				
hysic his ce	မ	1 🗆 Yes 2)					ER/Outpatie		Othe	er: 4 □ Nu	ursing Ho	me 5 🗆 Resid	dence 6	Othe	r (Specify)	KUNE	KE
tending P leath. tor: After t the funer	Certificate:	27. Manner of Deat 1 Natural 2 Accident 3 Suicide	h 5 ☐ Pending Investig 6 ☐ Could n	ation	nth, Day,	Year)	28b. Time of injury	м			. [28d. Describe I	now injury	occurre	ed		
oital or Att urs after o ral Direct illed in by		4 🗌 Homicide	determi	ned 28e. Place build	ling, etc.	(Specify)						28f. Location (S City or Tov	vn, State)				ber,
the Hosp thin 24 ho the Fune mpletely f	Medical	(Check 2 only one) 3	Medical E	Physician: To the caminer: On the ba Nurse Practitione	isis of exa	mination best of m	and/or inves ny knowledge	tigation, in , death occ	my opinio urred at t	n, death oche time, da	ocurred at te and pla	the time, date a ce, and due to t	nd place, he cause(and due s) and m	to the cau nanner as s	se(s) and ma tated.	
5 × 0 0		29b. Signature and	Morell	6) ann		up	· · · · · · · · · · · · · · · · · · ·	290	D3	number 1761		FRED	29d. Date	e signed	(Month, D	ay, Year)	
(A)			n.o.	CONNOR	up	ath (Item	23a) (Type, 1	Print)	EN7	7 ST	7.	FRED	ERIC	K,	MB	217	01
Stat	е	 Date filed (Mont 	n, vay, Year)	2013 32.7	Registrar'	s Signat	ure	1 .	,								

DHMH 17 Rev 06-2011

			101	ate of Maryland / Dep			∕lental Hyg	iene	
			State Registrar	Ce	rtificate of L	Death	T	eg. No. 2	2 34900
	Physicia	n/	1. Decedent's Name (First, Middle, Last) ELMER C.	CREGGER			2. Date of Deat	5 ^{Day} 2012	'ear 7:30 P M
	Medic Examin		4a. Facility Name (if not institution, give street a		4b. City, Town, or	r Location of Death	OCCODE	4c. County of	
			Kline Hospice House		Mount	Airy		Frede	
	Funeral		5. Social Security Number 6. Sex 220–28–8441 1 🕅 M 2	7. Age (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
-	Director		220−28−8441 1 🕅 M 2 Usual Residence of Decedent	P ■ F 82 Yrs.			June 21	,1930 V	/irginia
	land shov	tor	10a, State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	- 28a-i	Jirec	Maryland Frederick	Keymaı					1 ☐ Yes 2 🛣 No
	ith the	ral	10e. Street and Number 12505 Renner Rd.		10f. Zip Code 21757	7		Og. Citizen of What United S	
	eath w	Funeral Director	11. Marital Status 12. Wa	as Decedent Ever in U.S. 13	Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-		American Indian,
တ္ထ	fter de ", or it amine		1 ☐ Never Married 2 🛣 Married 📗 1	med Forces? A Yes 2 \sum No Yes Give 17	If Yes, specify Cuba 1 ☐ Yes 2 🕅 No		Rican, etc.)	Black, Specify:	White, etc. White
Ş	ours a atural' cal Ex	Completed by	3 ☐ Widowed 4 ☐ Divorced Ye	res, Give Korean	edent's Usual Occup				
15	72 h an "na Medio	mpl	(Specify only highest grade con	ipleted) (Give	e kind of work done (DO NOT use retired)	during most of work	ing	16b. Kind of Busin	ness/Industry
21.	withir giene ner th t, the		12	Busi	ness owne	r		Auto Dea	aler
and	e filed ntal Hi ed otl even	To Be	17. Father's Name (<i>First, Middl</i> e, <i>Last</i>) Luther	Cmanan		18. Mother's Nam			
Maryland 21215-0036	ould b		19a. Informant's Name/Relationship (Type, Prin	Cregger	ling Address (Street	Ada	Cas		to Zin Codo)
Š	d 2 sh alth ar 1 27 is er trau		Emily C. Cregger / w	1"	5 Renner				1757
Baltimore,	ge 1 and 2 should be filed within 72 hours after death with the Mayland to of Health and Mental Hygiene. A to fleath and Mental Hygiene. The winatural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remov	20b. Place of Disp	osition (Name of ematory or other place	ce)	Date	20c. Location - Ci	ity or Town, State
Ě	t. Page 1 tment of tant: If it tjury or o		4 Donation 5 Other (Specify)	Resthave					,Maryland
Ra	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		22. Name and Address Oposs				omes, P.A. D 21702
			23a. Part 1 Enter the disease, or complication shock or heart failure. List only one caus	is that caused the death. Do not er e on each line.	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
P	hydcian/	g. 3	Immediate Cause (Final disease or condition		hemia				Hours
	Medical Examiner		resulting in death)	Due to (or as a consequence of): Pancreatic Can					361
	The same of	ner		Due to (or as a consequence of):	cer				Months
	uted Id ransit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events c.						
	ate be executed oblysician and the burial-transit	al E)	resulting in death) Last	Due to (or as a consequence of):					
3	care by physic s the b	edical	d						
8	requires that the death certificate been signed by the attending phy should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If y	/es, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3				23d. Date of	of delivery
POX	death ie atte ed for	sicia	1 Ves 2 No	 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Pregnant at time of death 5 ☐ Unknown 	☐ Ectopic pregnand ☐ Other (specify) _	СУ		Month	· ·
5	of the contraction of the contra	Phy	9 Unknown Part II. Other significant conditions contribut		underlying cause al	ven in Part I	OZO Didas	one was centribe	ute to the cause of death?
ν, Γ. :	signer signer d be d	d by	Tartin Other significant conditions contribut	ng to death but not resulting in the	underlying cause gi	voiriiri aiti.			Probably 4X Unknown
Records,	been	Completed					24a. Was a	24b. Wei	re autopsy findings available
éc	ne law te has age 2	omp					autops perform 1 \sum Yes	neel? dea	or to completion of cause of ath? Yes 2 \sum No
	ertifica ctor, p	Be C	25. Was case referred to medical examiner?		26. PI	lace of Death (Chec		2 2 1 1 1 1	
r vital	rhysic this ce al dire	မ	1 Yes 2 No	1 Inpatient 2 ER/Outpati		4 U Nursing Ho		nce 6 X Other	Hospice Specify) House
0 ;	th. After funer	cate	1 🗡 Natural 5 🗆 Pending 2 🗀 Accident Investigation	a. Date of injury (Month, Day, Year) 28b. Time injury	work		28d. Describe ho	w injury occurred	
DIVISION OF	Aften er dea ector: by the	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At home, farm, s					or Rural Route Number,
≧ :	Ital or Irs aft al Dir lled in			building, etc. (Specify)			City or Town	, State)	
	To the topspiral or Attending Prhysician: The law requires that the deam value 24 hours after death. To the Funeral Director, After this certificate has been signed by the attention of the funeral director, page 2 should be detached for completely filled in by the funeral director, page 2 should be detached for	Medical	(Check 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or inve	stigation, in my opinio	on, death occurred a	t the time, date an	d place, and due to	the cause(s) and manner stated.
	Nithin Fo the	Σ	only one) 3 ☐ Certifying Nurse Prac 29b. Signature and title of certifier	titioner: To the best of my knowledg	e, death occurred at t 29c. License		L	e cause(s) and man 9d. Date signed (A	
			HECAZIND		DL	141104	4 1	October 8	8, 2012
	10 xiva		30. Name and address of person who complet			/ = -	• 1 • •	1 1	01700
	Stat		Zakaria A. Hegazi 31. Date filed (Month, Pay Yell) 0 0140			·/ Freder	rick, Ma	ryland 2	21702
	Registra		001 12 2012	frank B. A	barker				

Timothy Junior Church State of Maryland / Department of Health and Mental Hygiene 2012 3490 1- For State Certificate of Death Rea. No Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day October 16, 2012 **Medical Examiner** 1434 hrs Timothy Junior Church 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3074 Turkey Point Road North East 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or oreign Elkton CountyMaryland Months Days Hours Min Director 212-78-5582 1XXM 2 F 49 07/07/1963 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XXNo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Maryland Cecil North East Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3067 Turkey Point Road 21901 United States Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 White, etc. Yes 2 x No Specify: White 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter and Concrete Finisher Construction Itimore, MD 21215-0036 12 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Vernon Church, Jr. Nell Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Vernon Church, Jr./ Father 3067 Turkey Point Road, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State North Past Plusited October 23 4 Donation 5 Other Specify Methodist Cemetery 2012 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home, P.A. South Main Street, North East, Maryland 21901 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Death aMultiple Blunt Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed sician/Medical AMENDED 23a, 27, 28a-f per me, g933 11-14-12 sm this certificate has been signed by the attending physician al director, page 2 should be detached for use as the burial -X UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Fart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) å examiner? Hospital: 1 Other₄ 1 ✔ Yes Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural 5 Pending subject was a pedestrian struck by auto Director: 1 Yes 2 X No within 24 hours after death To the Funeral Director: 10-16-12 fd 1423 hrs 2 X Accident fd Investigation 28f. Location (Street and Number or Bural Route Number, City or Town, State) 3074 Turkey Point Rd North East, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined (Specify) 4 Homicide Roadway 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical the 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E October 17, 2012 30. Name and address of person who completed cause death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 3. Registrar's Signature State arka Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

inthony Celentan		ি For State Registrar	ate of Maryland	-	artment of rtificate of		na wenta	п нуді		g. No. 201	2 3490
Physiciar Medical Examin		1. Decedent's Name (First, Middle Anthony F. Cele							ate of Death lonth CtDber 10		3. Time of Death 1301 hrs
		4a. Facility Name (if not institution Frederick Memorial Ho	•)	,	4b. City, Town, Frederick	or Location of D	Death		4c. County of Dea Frederick	ith
Funeral Director		5. Social Security Number 120–24–4316	6. Sex 7. Ag	e (In yrs. 83	last birthday) Yrs	If Under 1 Ye Months Da		A dian		17, 1928 Fore	
any	F	Usual Residence of Decedent 10a. State 10b. County	•	10c. City	, Town or Locat						10d. Inside City Limits
land f show	ğ		roll				t Airy				1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 713 Midway Avenue				, 10f. Zip Code	21771			g. Citizen of What Co United State	s of America
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 23a-f shent, the Medical Examiner must be notified at one	Funeral	11. Marital Status 1 Never Married 2 Ma	12. Was Deceden Armed Forces 1 Yes 2			s Decedent of H es, specify Cub	lispanic Origin		Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,
rs after ural", o	2	3 X Widowed 4 Divo	orced If Yes, Give Year or Dates: ify only highest grade cor	noleted)		Yes 2 🗶 N		d of work	done I	Specify: Wh	ite s/Industry
5-0036 style of the style of th	Completed	Elementary/Secondary (0-12)	College (1-4 or		during m	ost of working li	fe. DO NOT us	e retired)			,
15-003 filed within Hygiene. d other that	e E	12 17. Father's Name (First, Middle,	Last)		Self Em	ployed Bu			t, Middle, M	Retai aiden Surname)	1
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than ic event, the Medica	Be	Frank Celentano							Casella		
MD 21 id 2 should lith and Me m 27 is man] ۲	19a. Informant's Name/Relationsh Frank Celentano /								ber, City or Town, Sta	
ore tr	l	20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from St	ate	Place of Dispos crematory or oth	ner place)		Octobe	r 12,	20c. Location - City of Smithsburg	
Baltimore, permit. Pages la Department of He Important. If ite injury or other tr	-	4 Donation 5 Other Special Service I		Sm	ithsburg 22, N	Crematory Iame and Addre ency & Ba		201			, raryram
		23a. Part I. Enter the disease, or o			1433 10	6 East Ch	urch Str	eet. F	rederic	ck. Maryland	21701 Approximate Interval
Physician /Medical Examiner		failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		ive A	therosc						Between Onset and Death
to comment	اء	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons								
p is	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons			-					
50, te be executed ysician and burial - transit	ledical E	X UNPENDED	d	,pt.	11,27,2	Ba-f,pe	r me,g9	33 11	L-14-1	2 sm	
of Vital Records, P.O. Box 68760, ig Physician: The law requires that the death certificate be executed first this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit	2	IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outco		2 Fe	tal death 3	Ectopic pr	regnancy		23d. Date of delive Month	ery Day Year
Box ne death the atte	Š	1 Yes 2 No 9 Unkr	9 Unknown						22 - Did tol		o the cause of death?
res that the d signed by the be detached		Part II. Other significant condition Right Hip Fra	-		resulting in the u	inderlying cause	e given in Part i				obably 4 Unknown
of Vital Records, as Physician: The law require the this certificate has been shortly rape 2 should the things of	Completed by							_	24a, Was a autops perforn 1 Yes 2	y prior to ned? death?	
tal Recition: The lector, page	် ရ	25. Was case referred to medical examiner?				26,Pla	ce of Death (Cl	heck only o		NO	2 10
Physic Physic er this c	의	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatient		Other N	lursing Ho		Residence 6 Oth	er:
~ ∄ _ < ₽ ;	tion	1 Natural 5 Pendi	(Month, Day,)	'ear)	fd 14:4	1	Yes 22 N	1		fell	
Division Hospital or Attendin 24 hours after death Funeral Director: A stely filled in by the fu	Certification:		not be 28e. Place of Ir		nome, farm, stree		building, etc.			ate) 713 Midw a	Rural Route Number, City Ave.
0 - 3 - 1 -	ल	29a. Certifier 1 Certifying Ph	ysician: To the best of m	-	-			, and due	to the cause	e(s) and manner as st	
To with To con	ğ-	29b. Signature and title of certifier	and manner stated.				nse number			29d. Date signed (M	
		Puntity Washell	(M)	leath /Iten	n 23a)	0.0	C.M.E.	_		October 11, 20	12
		Pamela E. Southall, M			•) W. Baltimo	re Street, E	Baltimor	e, MD 21	223	
Sta Registra	_	31. Date filed (Month, Day, Year)	012 Zee	409	ure par	and a					

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **JOSEPH** PATRICK DAY JR. A M OCTOBER 10, 2012 2:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 5800 Connecticut Avenue Chevy Chase Social Security Numbe If Under 1 Year If Under 24 Hrs. 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 02/07/1938 004-32-4457 1 X M 2 🗆 F 74 Director Maine Usual Residence of Decedent show e filed within 72 hours after death with the Maryland ntal Hygiene.
ed other than "natural", or items 23a or 28a-f shot event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase 1X Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20815 5800 Connecticut Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian d Forces? Yes 2 ☐ No **POST**— Black, White, etc 1 Never Married 2 Married ģ 1 X Yes Maryland 21215-0036 If Yes, Give Year or Dates.**--KOREAN** 1 ☐ Yes 2 👿 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working United States life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Clerk Postal Service Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ 27 is marked er traumatic e Pauline Singer permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Joseph Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Day / Son <u>237 North Bryan Street Arlington, Virginia 22201</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia National Crematory 10/13/12 Signature of Funeral Service 22. Name and Address of Facility Joseph Gawler's Sons LLC. Willes - M00063 5130 Wisconsin Avenue NW Washington, DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ BLADDER CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of if a y, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed sician and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death I signed by the a Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> MYOCARDIAL INFARCTION Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed page 2 should HYPERTENSIVE VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 death? certificate 2 No ☐ Yes thin 24 hours after death.

the Funeral Director: After this certifical mpleted filled in by the funeral director, I Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes |2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours
To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C OCTOBER 11, 2012 #MD 33255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING ST. NW, WASHINGTON, DC 20422/688 31. Date filed Registrar's Signature 15 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Day 4 Elizabeth Louise Dennard 2012 P^{M} 7:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Min Hours (Month, Day, Year) Director 199-03-9433 1 🗆 M 2 💢 F 94 1918 3, Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 525 Glenburn Avenue 21613 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Seafood Packer Coldwater Seafood 11-Graduated permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winnie Hopkins Daisy Mae Demby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Dennard-Turner/Daughter 5838 Richardson Rd., East New Market, MD 21631 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Washington Cemetery 10/13/2012 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home 216 N. Main Street, Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysiciani cerebra Va5cular Wears Medical resulting in death) Due to (or as a consequence of) Examiner dementia Sequentially list conditions, ied r S if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nupertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy After this certificate ! 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No |@ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this letely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 06-2011

State Registrar

within 2

only one)

29b. Signature and title of certifier

nain

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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DHMH 17 Rev 7/2009

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10			30. Name and address of person w	to completed cause of		a) (Type, F ذ	Print) 1940 1	=aster "	1 Aveni	ve. Ba	Hinne	MD 21224
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34907 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katherine Virginia Blumenauer Danner 2012 October 10, 1:38 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Glade Valley Nursing & Rehab Center Walkersville Frederick If Under 1 Year If Under 24 Hrs.
Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 213-18-8555 1 □ M 2 🗓 F 91 10/03/1921 Maryland Usual Residence of Deced or 28a-f show notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Frederick Walkersville 1 X Yes 2 □ No 10e. Street and Number ō ms 23a or must be 10g. Citizen of What Country? Funeral 300 Chapel Ct. #213 21793 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or iter Medical Examiner 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 □ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) er than the Me Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Catalog Dept. 12 Typist Frederick Trading Co. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental Ith some marked of traumatic eve Charles D. Blumenauer Katherine Schade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) age 1 and 2 sh nt of Health a t: If item 27 is or other trau Robert W. Fogle, Jr./grandson 8997 Grape Creek Rd., Walkersville, MD 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Resthaven Mem. Gardens 10/12/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. lin 40 Fulton Ave., Walkersville, MD 21793 Part 1. Enter the disease, or complications that caused the de that o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Oriset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year the a Pregnant at time of death Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has performe 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and ti 29d. Date signed (Month, Day, Year) 026516 OCTOBER 11 2012

State Registrar Date filed (Mo

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GUITORDINR

FREINERICK MD 2/30

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 OLIVIA N. DRONEBURG October 2:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 307 E. Third St. Frederick Frederick 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** Days Hours **Director** 215-14-2145 1 M 2 X F 92 12/23/1919 MD Usual Residence of Decedent show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f 1 X Yes 2 □ No MD Frederick Frederick 20 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a must l 307 E. Third St. 21701 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ ò 1 Never Married 2 Married Yes 2 X No Yes, Give and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 X Widowed 4 Divorced Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the factory worker Air Pax Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ၉ Walter Federline Emma Rothenhoefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Claude Droneburg, Jr./son 307 E. Third St., Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Page 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mt. Olivet 10/13/2012 Frederick, Signature of Funeral Service Lic 22. Name and Address of FacilityStauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease shock, or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ oronari Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical ase yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No 9 Unknown for Month Year Pregnant at time of death Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No this certificate 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNo ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 1 Natural 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending

Box 68760 P.O. Records, Division of Vital or Attending Physician: after death. funeral director, To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After filled in by the

> State Registrar

Medical

Accident
Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and

Investigation

Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signature

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1/🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10/11

29d. Date signed (Month, Day, Year)

				Pleas	e Type or Pri						_		_	ole.	
込			For State Registrar		State of M	larylan		partmer <i>ertificat</i>			Mental Hy	ygien Reg. N	201	2	34909
न्ह	Physicia		1. Decedent's Nam	e (First, Middle, L Francis	,						2. Date of D Month Octobe	eath		'ear	3. Time of Death 9:45 P. M
	Medie Examir				ve street and number)	Center	^			r Location of Deat lerick			c. County of		
F	Funeral Director		5. Social Security N 219-14-92		Sex 7. Ag	ge (In yrs. la	ıst <i>birthd</i> ay Yrs.	y) If Unde	r 1 Year Days				T	9. Birth	place (State or Foreign stry) vland
		<u>ا</u> ة	Usual Residence of 10a. State	Decedent 10b. County			, Town or	Location			inug. 1	.0 , 1 .	723		VI dIIQ 10d. Inside City Limits
	e Maryla • 28a-f s notified	Directo	Md. 10e. Street and Nur	Freder	rick		Fre	derick							1 □X√es 2 □ No
	h with the	Funeral Director			cle # 3C			10f. Zip	217	02		10g. C	itizen of Wh	at Cour • A	ntry?
2012 1215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2 X Married 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.	Ever in U.S No 41-	-46	3. Was Deced If Yes, spec 1 \(\subseteq \text{Yes} \)		ispanic Origin? (S In, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Black, Specify:	White,	
2012	n 72 hou an "nat Medica	Completed	(Spe	15. Decedent's ecify only highest g		5.1)	(Giv	cedent's Usua ve kind of wor . DO NOT use	rk done d	ation during most of wor	rking	16b.	Kind of Busi	ness In	dustry
-00	ed withii Hygiene other th	0	17. Father's Name (Indu	ustria	l En	gineer	(T)		blic S	Serv	/ice
D.O.D. 10/13 Baltimore, Maryland	Ild be file Mental narked o	To I		C. Darn		_				18. Mother's Nai	ry Eliz			1ke	
O N	d 2 shoualth and 27 is mer traum	-	19a. Informant's Na				1			and Number or Ru Circle #		_			
More.	Page 1 and ment of Her ant: If item ury or othe		20a. Method of Disp	oosition [X] Cremation 3 [Date	20c. l	Location - C	ity or To	own, State					
	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.		4 Donation 21. Signature of Fu	5 Other (Spec	ree			urg Cr 22. Name an			$20\overline{12},$	1			y Ave.
	89 = 89		3a Part 1 Enter t	the disease or con	1 Avis	MO14				Funeral	Home S	mith	sburg	,Md	21783
y.	Physician/	0 4	shock, or hear Immediate Cause (disease or condition	rt failure. List only Final	one cause of each line	9.	tea		c or dym	g, saon as cardiac	or respiratory a	inesi,			Approximate Interval Between Onset and Death
5	Medical Examiner		resulting in death)	(Due to (or as	a consequ	ence of):								2 701.2
Dane	ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlying	b. Due to (or as	a consequ	ence of):								
Ã	e executed sian and urial-transit	al Exa	that initiated events resulting in death) t	s i	C. Due to (or as	a consequ	ence of):							\top	
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE; 23b. Was decedent in the past 12 r 1 Yes 2 Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	B		у			23d. Date of Month		ery Day Year
2.45.0	res that 1 signed b				contributing to death b	out not resu	ulting in the	e underlying o	cause giv	en in Part I.					ne cause of death?
hul Sicuory (aw requii as been 2 should	Omosia solutions communities of the solutions									24a. Was	an	24b. We	re autop	osy findings available mpletion of cause of
Bel	n: The la ficate ha or, page		25. Was case referre	ad to madical							perf 1 ☐ Yes	ormed?	dea	ith?	2 No
<u>र</u> ्ड्	nysicia nis certi directo	To Be	examiner?	€ No	Hospital:	ent 2 🗆 E	ER/Outpati	ient 3 🗆 DC	Othe	ace of Death (Che	ok only one) Iome 5 🗆 Resi	idence	6 🗌 Other (Specify)
9 E	nding Pl ath. :: After th e funeral		 Manner of Death Matural Accident 	n 5 ☐ Pending Investigatio	28a. Date of inju (Month, Day	ry y, Year)	28b. Time injury		8c. Injury work	at	28d. Describe				
Knawn to P	tal or Atterns after destal Directored in by the	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	be 280 Place of lair			street, factory	, office		28f. Location (City or To			r Rural	Route Number,
m o(the Hospital hin 24 hours a the Funeral I mpleted filled	Medical	(Check 2	Medical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or inve	estigation, in r	ny opinio	n, death occurred	at the time, date	and place	e, and due to	the cau	use(s) and manner stated.
P.	To th within		29b. Signature and t	title of certifier	Cymin				License	number 48		29d. Da	ate signed (A		Day, Year)
	5 91				completed cause of d				rick	,Md. 217	01				
	Stat Registra	_			32. Registra										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Edynak Michael Oct.6,2012 6:11a^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Spring Lake Drive #C1 Bethesda 7551 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days 1 1 / 2 0 / 1 9 1 1 Delaware 100 201-10-7665 Director 1 X M 2 | F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Bethesda 1 Yes 2K No Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 7551 Spring Lake Drive #C-1 20817 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Federal Welder Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Julia Shatynski Michael Edynak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20817 7551 Spring Lake Drive #C-1 Bethesda, Md. 19a. Informant's Name/Relationship (Type, Print) Gloria Edynak/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State 10/13/2012 Linwood, PA. Lawn Croft Cem. 4 Donation 5 Other (Specify) Funeral Service 21. Signature PHYMERE ACCEPTION ACCEPTION ALL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final atheroschousis Physician/ Loronar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and are completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Division of Vital Records, P.O. Box 68760 Certificate: To 28a. Date of injury (Month, Day, Year) 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one)

> 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) G.Cdleman M.D.

29b. Signature and title of certifier

6001 Muncaster Mill Road Rockville, Md 20855

D37142

29d, Date signed (Month, Day, Year) Oct.6,2012

29c. License number

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0445 M Benjamin Franklin Elliott, Sr. Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death YEHINSULA REDIDARDL SPL | SBU! HICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Country) 218-12-1898 Director 1 🗓 M 2 🗆 F 92 Feb. 15, 1920 Maryland i and 2 should be filed within 72 nous acce.
If Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show
Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico 1 Yes 2 No Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25074 Delmar Road 21837 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🖾 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer <u>Agriculture</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Elliott Madora Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Elliott (Wife) Mardela Springs, MD 25074 Delmar Road Department of Health Important: If item 2 any injury or other t 21837 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mardela Memorial Cem. 10-14-2012 Mardela Springs, MD nature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Spiration disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physiclan and I for use as the burial-transit Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day signed by the at id be detached for g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? 2 D No Hospital: Other: ည 1 Unpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hediçal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and provised the best who completed cause of shall (tem 234) (Tipe Print) WENTERPLACE PIC ZIECY SUITE 103 SMUS BUY State 32 Registrar's Signature Registra

DHMH 17 Rev 06-2011

		4	For State	State of	Maryland		rtment of H		/lental Hyg	ilene	1.0	01010
			Registrar 1. Decedent's Name (First, Middle,	l ast)		Cer	tificate of D	eatn	2. Date of Deal	leg. No. /	12	3. Time of Death
	Physicia	n/	Theodore	Edel	0 ~				Month	O Day	Year	1244pM
	Medic Examin		4a. Facility Name (if not institution,	give street and numb	per)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Anne Arundel				Annapol					ındel
	Funeral		5. Social Security Number 2 2 0 - 3 8 - 1 1 3 6		7. Age (In yrs. la		if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Coun	
	Director		Usual Residence of Decedent	1 🔀 M 2 □ F	71	Yrs.			04/22	/1941	Mary	land
	land shov	ţ	10a. State 10b. County		10c. City	, Town or Loc	cation				1	0d. Inside City Limits
	28a-	Director	MD Char	Les	Fau	lkner				10.000	MII 4 0 - 1 -	1 Yes 2 X No
	ith the		10e. Street and Number 10201 Popes (Trook Dd			10f. Zip Code 20632			10g. Citizen of Unite		
	ems	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S		Vas Decedent of Hi			14. Rad	e - Americ	an Indian,
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	ed Armed Force 1 Yes If Yes, Give Year or Dat	2 🔀 No	-	f Yes, specify Cuba ☐ Yes 2 🌠 No		Hican, etc.)		ck, White, o	
21215-0036	hours natur dical l	Completed		t's Education at grade completed)		16a. Deced	lent's Usual Occupa	ation	ina	16b. Kind of B	lusiness/Inc	dustry
2	hin 72 ne. than '	E O	Elementary/Secondary (0-12)	College (1-4	4 or 5+)	life. Do	O NOT use retired)			Seven	C + ~ ~	7 ~ ~
ห่	Hygie	Truck Driver Truck Driver 18. Mother's Name (First, Middle, Last)										Agg.
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Maryland	hould and M is mai		19a. Informant's Name/Relationsh			19b. Mailin	ng Address (Street a	and Number or Run	al Route Number	City or Town,	State, Zip (Code)
Σ̈́	ealth a m 27		Arnell Edele	1/Spouse			1 Popes					ID 20632
Baltimore,	ge 1 a it of H or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation		e)	Date	20c. Location Alexan	-				
≝	artmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (S 21. Signeture of Funeral Service L	- 12	мет	. Name and Addres						
Ba	permit Depar Impor any in	1 P	Manal	Ave.,	La Pla	ta,	MD 20646					
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that can nly one cause on each	aused the death th line.	n. Do not ente	er the mode of dyin			est,		Approximate Interval Between Onset and Death
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to 6	Then	vre	weart	Misic	-12	and	-+	
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	+	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a nunseus	ende of:	melly					
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3760	ficate g phys											2000
ŏ ×	h certi tendin or use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Birth 2 ☐ Feta	Ideath 3	Ectopic pregnanc	су			ate of deliv	rery Day Year
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	Completed by Physician/M	1 Yes 2 No	4 ∐ Pregr 9 ☐ Unkn	nant at time of o	leath 5 L	☐ Other (specify)					
P.0	that the	by P	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	underlying cause giv	ven in Part I.	23e. Did to	,		he cause of death?
ds,	quires	ted	17 yearth	y inn								obably 4 Unknown
S	law re has be je 2 sh	mple					-		24a. Was autop		Were auto prior to co death?	ppsy findings available ompletion of cause of
Ä	n: The ficate or, pag		25. Was case referred to medical	10			26 D	ace of Death (Chec	1 🗆 Yes		1 Yes	2 🗆 No
/ita	/sicial s certi directe	To Be	examiner?	Hospital:	Inpatient 2.	ER/Outpatie	nt 3 DOA Oth	or.	lome 5 🗆 Resid	dence 6 ☐ Oti	her (Specifi	v)
of	ng Phy ter thi		27. Manner of Death	28a. Date o		28b. Time of injury		y at </th <th>28d. Describe h</th> <th>ow injury occur</th> <th>red</th> <th></th>	28d. Describe h	ow injury occur	red	
<u>o</u>	ttendir death. ctor: Af y the fu	Certificate:	Accident Investig	gation			-	Yes 2 □ No	2011 1: 10	N	h O	/ Davida Nilmahar
ivis	after a Direc		4 Homicide determ		of injury - At no ng, etc. (Specify		eet, factory, office		City or Tow		oer or nura	al Route Number,
	To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical		Physician: To the be	est of my know	ledge, death	occurred at the time	e, date and place,	and due to the ca	ause(s) and mar	nner as sta	ted. ause(s) and manner stated.
	the H hin 24 the Fi	Ψě	unity one) 3 Certifying	Nyrse Practitioner	To the best of r	ny knowledge	Joath prounted at I	the time, date and p	lanv, and due to t	his consule) and	manner as	stated.
	ខ្ទុំមុ		29b. Signature and title of certifie		in		29c. Licens	33/10/ ₋		29d. Date sign	еа (Month, - 2.D/	Day, rear)
	6 gr		30. Name and address of person	who completed caus	e of death (Item	23a) (Type, I	Print)	22706				
	A 11.		B. Larry Jen,	kins M.	D. F	20. B	10x 2663	Lapl	ata m.	D 2064	16	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 3 1 201	2 / 32. R	egistrar's igna	Jank.	29c. Licens D 00 Print) D X 2665					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 9 Day 2012 Year Physician/ 10:15 A.M Arthur Angelo Ferrara Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth Month, Day, Year) Aug. 19,1918 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Director Pennsylvania 94 150-09-7456 1 XM 2 F Usual Residence of Dece th and Mental Hygiene. 27 is marked other then "neturel", or Items 23e or 28e-f show traumetic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Prince Georges 1 🗌 Yes 2 🛛 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20904 United States 3152 Gracefield Road Apt. 111 12. Was Decedent Ever in U.S. Armed Forces?

↑ Yes 2 □ No If Yes, Give WW II Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۾ 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Electronic Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Venerando Ferrara Sarah DiBella permit. Pege 1 and 2 should be Department of Health and Mer Importent: If item 27 is marke eny injury or other traumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9712 Ambergate Ct., Gaithersburg, MD 20882 Donna F. Householder/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of October 20c. Location - City or Town, State George town on the state 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 Other (Specify) Medical 2012 Center Signature of Funeral Service Licens 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 e 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Pulmonary Embolisim disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician end for use es the burlal-transit Exami Physician: The lew requires that the death certificete be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Whithown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed? Yes 2 -No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this c completely filled in by the funeral direction. ဥ 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0036716 October 10, 2012 * nouv 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road Andrew Kundrat, M.D. Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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P.O.

Division of Vital

			1 - State of Maryl Registrar		artment of H tificate of D			giene Reg. No. 20	12	34914
ì	Physicia	n/	Decedent's Name (First, Middle, Last) Delos Faulkner				2. Date of Dea		⊒ Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	100	4c. County		1. 10 L W
			9123 Susan Ln. 5. Social Security Number 6. Sex 7. Age (In y.)		Clin	ton If Under 24 Hrs.	Lan. (Div	Princ		
	Funeral Director		497-22-971.2 W	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day	; Year)	9. Birthp Count	
	nd how at	'n	Usual Residence of Decedent	City, Town or Lo	cation		03/24/	1927	11	KA 0d. Inside City Limits
	Vfarylar 18a-f s stified	Director	MD Prince Georges	Clinton						1 X Yes 2 □ No
	th the I 3a or 2 t be no	al Di	10e. Street and Number		10f. Zip Code			10g. Citizen of V	What Coun	*
	eath wi	Funeral	11. Marital Status 12. Was Decedent Ever in		Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-	14. Race	e - America	
36	after d	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 🛣 Yes 2 ☐ No If Yes, Give		Yes, specify Cuban Yes 2 X No		Rican, etc.)		k, White, e	
5	hours natura lical E	etec	15. Decedent's Education		lent's Usual Occupa			16b. Kind of Bu		
21215-0036	thin 72 ene. than "	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	life. Do	kind of work done du D NOT use retired) Writer Rej		ing	US Go	vern	nent.
מ פר	filed within 72 hours after death with the Maryland al Hygiene. of other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	ryper		18. Mother's Nam				
Maryland	Ild be Ment larke	O.	Lester Faulkner			Pearl l				
Ma	short and short	1	19a. Informant's Name/Relationship (Type, Print) Gloria Faulkner / wife		ig Address (Street ai Susan Ln•				tate, Zip C	ode)
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once.		1 🛭 Burial 2 🗆 Cremation 3 🗀 Removal from State		natory or other place)	Date	20c. Location -	City or To	wn, State
	nit. Pag artmen ortant: injury injury	3	4 ☐ Donation 5 ☐ Other (Specify) ☐ 21. Signatur of Funeral Spirice, lice (see //	The second secon	Nat'l C			Suitlan		
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E E	ician: T	Be	25. Was case referred to medical examiner?		26. Plac	ce of Death (Check		2 23 140		- Parto
0 0	g Phys er this neral di	te: To	27. Manner of Death 28a. Date of injury	28b. Time of	t 3 L DOA	4 □ Nursing Ho at	me 5 🔀 Reside 28d. Describe ho			
00	tendin death. tor: Aft the fur	Certificate:	2 Accident Investigation			/es 2 □ No				
DIVISION OF	al or At s after of I Directed in by		4 Homicide determined 28e. Place of Injury - Arbuilding, etc. (Spe	t home, farm, stre	et, factory, office		28f, Location (St City or Town		er or Rural i	Route Number,
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	To the within ?	Σ	only one 3 Certifying Nurse Practitioner: To the best 29b. Signature and title of certifier	of my knowledge,	death occurred at the			e cause(s) and m 29d. Date signed	-	
	3.		· / · / · / · / · · · · · · · · · · · ·			14535		70/17	/5075	
	44		30. Name and address of person who completed cause of death (In Dr. Laxmi N. Berwan M.D., 770)			л HClOl¬	Clinto	n, MD 20	3735	
	Stat Registra	_	31. Date filed (Month, Day, Year) OCT 1 6 2012 32. Registrar's Signature 34. April 1. Apri	an eturo		. —		 .		
	ricgistic		HILL - VIVIL LANDOWY FOR 1991							

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2<u>9</u> Allen Foster 2012 September P^M 1:04 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8541 Greenbelt Road # Prince George's Greenbelt Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Min. Director 577-70-1430 1 [™] M 2 □ F Yrs 61 April 18, 1951 show 10b. County 10c. City, Town or Location the Maryland notified at Director 10d. Inside City Limits 28a-f s 1 XYes 2 No Greenbelt Maryland Prince George's 23a or 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? pe Funeral with 20770 United States <u>8541 Greenbelt Road # 202</u> items death v Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Completed by Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after toppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event: the Madical Examination of the property in the Madical Examination of the property in the Madical Examination of the property in the Madical Examination of the property of 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Engineer Metro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ O.C. Foster Elizabeth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Oglethorpe Street # 201 Hyattsville, Maryland April Carter - Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. Date . cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2012 Clinton, Maryland 21. Signature of Funeral Service Licenses Stewart Funeral Home, Inc. 22. Name and Address of Facility Washington, DC 4001 Benning Road NE M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Atheroscleosis of Aorta Sequentially list conditions, Due to lor as a nonnectionne of cause. Enter Underlying Cause (Disease or injury Exami I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Hypercholesterolemia burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown ate has been signed by a page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital. မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred X Natural iniurv 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours aft To the Funeral Di Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066377 October 10, 2012 12W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Seiger, MD 6104 Old Branch Drive Temple Hill, Maryland 20748 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death Examiner County of Death 7. Age (In vrs. last birthday) If Under 1 Year 8 Date of Birth Birthplace (State or Foreign Country) Funeral 76 Director 212-34-2231 1X M 2 D F MD 08/10/1936 of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercitan must be in Affled at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5373 Hesperus Drive 21044 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1X Yes 2 ☐ No 1 ☐ Yes 2 No Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry John P. Finnegan Elementary/Secondary (0-12) College (1-4 or 5+) Construction Co., Inc. Builder Be permit, Page 1 and 2 should be filed.
Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic evem 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Joseph Finnegan Elizabeth Marie Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Patricia Finnegan - wife 5373 Hesperus Drive Columbia, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 10/18/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: res, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at be detached f 1 Yes 2 L g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ ER/Outpatient 3 DOA 1 Inpatient 2 Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 🗌 Pending work? 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one e and title of certifier 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 15+ State Registrar

Maryland 21215-0036

Box 68760

Records,

of Vital

Division

arlene F. Frank	ow	Sky S 1- For State	tate of Maryla	and / Depa	artment o rtificate o	of Health a	and Men	tal Hyg	giene	gible.	12 3491
Physicia	an/	Registrar 1. Decedent's Name (First, Mide	dle,Last)		runcate C	Dealli		12	Re Date of Deat	g. No	1 0 1 3 1
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		320 Hollingsworth Ma	anor			Elkton				Cecil	
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5-0036 led within 7. Hygiene. other than	ဒ္ဓ	17. Father's Name (First, Middle	, Last)	-		-	18.Mother	's Name (F	irst, Middle, M	laiden Surname)	
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Heal	-1	20a. Method of Disposition		20b. I	Place of Dispo crematory or o	sition (Name of	cemetery,	D	ate	20c. Location - Cit	y or Town, State
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vision of Vital Records, P.O. Bo. or Attending Physician: The law requires that the dealt dred cath. Director: After this certificate has been signed by the att in by the funeral director, page 2 should be detached for	S C	Part II. Other significant condit	ons contributing to c	death but not re	sulting in the c	underlying cause	given in Par	rt I.	23e. Did too	acco use contribute	to the cause of death?
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Div To the Hospital or within 24 hours aft To the Funeral Di completely filled in	Medical	29b. Signature and title of certifie	and manner star	ted.			nse number	a. rou at the			
	-	111			MA					29d. Date signed (
	L	10/1			(11)		.M.E.			October 10, 20	J12
		30. Name and address of person Russell Alexander MD				M. Dalii	- 01		140		
		31. Date filed (Month, Day, Year)				W. Baltimore	e Street, E	aitimore	e, MD 2122	23	
Sta Registra		10 1 3 1 2012	Sz. Regi	istrar's Signatur	areas						
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State Registrar 31. Date filed (Month, Day, Year)

OCT 16

_asnawn Petrina		1- For State Registrar Certificate of	f Death	Reg. No. 2012 349	
Physici Medical Exami			2. Date of Month Octob		
		4a. Facility Name (if not institution, give street and number) Fort Washington Hospital	4b. City, Town, or Location of Death	4c. County of Death	_
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Fort Washington If Under 1 Year If Under 24Hrs. 8. Date	Prince George's e of Birth(MM/DD/YYYY) 9. Birthplace (State or	
Director		220-02-9002 1 M 2 MF 41 Yrs	Months Days Hours Min.	/07/1970 Foreign Wash.,	
ì		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion	10d. Inside City Lin	nits
te Maryland or 28a-f show any fied at once.	tor	MD Prince Georges Fort	Washington	1 X Yes 2	No
e Mary or 28a-	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
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0036 within jiene.	Completed by	12th Heal	th Care Aid	Private Industry	7
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First, Middle, Last) Phillip George	18.Mother's Name (First, Mi Leslie		
21, hould b ad Men is mar	70	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Rout	te Number, City or Town, State, Zip Code) 2074	
, MC and 2 sl ealth ar em 27 trauma		Nate' George/Daughter 8336 20a. Method of Disposition 20b. Place of Dispos	Indian Head HWY #	B2, Fort Washington,	M
Baltimore, bermit. Pages 1 am Department of Heal mportant: If iten njury or other tra		1 Burial 2 X Cremation 3 Removal from State crematory or other	her place) 10 / 23 /	12	
altin mit. P partme portan ury or		4 Donation 5 Other Specify Chesapea 21. Significant Fungral Service Licensee 22. N	ke Crematory 'Alame and Address of Facility Austin	Beltsville, MD Royster Funeral Hom	ne
		38	21 14th Street, NW	Wash.,DC 20011	- 1
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T. 8 5 E		(Check only 1 Certifying Physician: To the best of my knowledge, death occurr			_
To the Hos within 24 h To the Fuc	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	ion, in my opinion, death occurred at the time, 29c. License number	, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)	
1-PEND		PT 0 - 200.	O.C.M.E.	October 3, 2012	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)			_
			900 W. Baltimore Street, Baltimore	e, MD 21223	_
St Regist	ate rar				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Greer. October James Arthur Sr. ľő, 2012 11:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Kensington Park Assisted Living Kensington Montgomery Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 579-24-3852 Director 1 1 M 2 □ F 87 Sept. 26, 1925 Maryland Usual Residence of Dece permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Marical Examination once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10q. Citizen of What Country? Funera 3813 Palmira Lane 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.1943-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Plumber Private Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grover Greer Mary Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2628 North Florida Street, Arlington, VA 22207 Cynthia Greer Impala/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 16, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring, MD 20901 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) a Aspiration Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): outs are used.

Interest Director: After this certificate has been signed by the ettending physicien and filled in by the funeral director, page 2 should be detached for use as the burial-transit. or Attending Physician: The law equires that the death certificete be executed Cause (Disease or injury Peripheral Vascular Disease that initiated events resulting in death) Last Due to (or as a consequence of): Coronary Artery Disease Box 68760 Physician/Medi 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Dav Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dry gangrene of right foot, Dementia 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autoosy ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ROther (Specify) Facility ᇛ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funerel D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53691 Oct. 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, MD 3200 Tower Oaks Blvd., Rockville, MD 20852 31. Date filed (Month, Day, Year) 62. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:51 p FRANCIS N GREENLEE OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6705 CENTRAL HILLS TERRACE HYATTSVILLE PRINCE GEORGES Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 577-64-0610 **Director** 1 X M 2 🗆 F 61 11-14-1950 WASHINGTON, DC or than "neturel", or Items 23a or 28e-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGES HYATTSVILLE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6705 CENTRAL HILLS TERRACE 20785 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. Never Married 2 Married ₹ 1 ☐ Yes 2 👿 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpBI_ACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) IT - SPECIALIST DEPT OF DEFENSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file h and Mental | 7 is marked o ပ CRAWFORD GREENLEE SR THELMA PAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh.
Depertment of Heelth an
Importent: If item 27 is 1 MICHAEL GREENLEE - SON 6705 CENTRAL HILLS TERRACE, HYATTSVILLE, MD 20785 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-15-2012 Washington, DC Glenwood Cemetery 21. Signature Funeral Service Licensee 22. Name and Address of Facility RONALD TAYLOR II FUNERAL HOME 10583 MIDDLEPORT LANE, WHITE PLAINS, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (as a consequence of: Examiner Sequentially list conditions, d ary, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Hospital or Attending Physicien: The law requires that the death certificete be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 es the attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 1 Yes 2 L 9 Unknown the P.O. ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autonsv this certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 🛣 No Division of Vital director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) M. 7 18062141 /10 12 320 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERCANTILE LANE, LARGO MS

State Registrar

1221

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
end#15perFH FCHD KS 10/12/12 amend #19b per FH FCHD TM 10/17/12
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 9:48 РМ MARC **GOLDBERG** Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Months (Month, Day, Year) Country) 419-48-1752 1 X M 2 □ F Director Yrs 75 April 29,1937 New York permit. Pege 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth and Mentel Hyglene. Important: If Item 27 is merked other than "neturel", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examinar must be natified at appear. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 USA 1302 Baker Place East, Apt.#12 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S.
Armed Forces?
1 ∑ Yes 2 □ No 1957 —
If Yes, Give
Year or Dates. 1959 Black, White, etc. Š 1 Never Married 2 XMarried 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner & Operator Alarm Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Irene Kleinman Solomon J. Goldberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 Bater Place E., Apt.#12, Frederick, MD 21702 Deborah Goldberg / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2012 Resthaven Memorial Frederick, Maryland Stauffer Funeral Home 21. Signature of Funeral Service Lie 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the diseashock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical sulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Exam ettending physicien end I for use es the burlei-trensit Hospitei or Attending Physicien: The lew requires thet the deeth certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death ☐ Yes 2 ☐ No ils certificate has been signed by the director, pege 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours effer deeth. Funerei Director: After this etely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD51610

State

Registrar

Frederick

32. Registrar's Signature

ARIAM.

2170

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Guilfo

2

7115

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HEINRICH DOROTHY 2012 Year October 12:21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center Olney Montgomery 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 214-28-0719 1 M 2 XF 81 June 28, 1931 NY Usual Residence of Deced show 10c. City, Town or Location Director 10d. Inside City Limits 28a-f s 1 Yes 2XX No MD Rockville Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 14635 Bauer Drive, Apt. 311 20853 USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify:White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Secretarial Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pasquale Donofrio Lena Casasanta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Heinrich/Son 907 Ednor Road, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 ื Cremation 3 🗆 Removal from State cemetery, crematory or other place) Oct. 15 2012 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 21, Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ RENAL FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Secure fields list error fitter a Examine if any, leading to immediate cause. Enter Underlying Frans. URINARY TRACT INFECTION Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) burialsigned by the attending physician d be detached for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be hin 24 hours after death.

the Funeral Director; After this certificate has been signed by the attending physicis IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATORY FAILURE 1 Yes 2 No 3 Probably 4 Tunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No 1 ☐ Yes 2 X No ☐ Yes npletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation

Division of Vital Records, P.O. Box 68760

6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

only one) 29b, Signature and title of ce

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

02657

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRV (NG MIZUS, MD 10605 CONC

KENSINGTON, MO 20895 10605 CONCORD ST

State Registrar

Medical

31. Date filed (Month, Day, Year) **OCT 1** 6 2012

To the within 2 To the F

			For State Registrar	State of Ma	arylan		artment of tificate of		d Mental H	lygiene Reg. No	2012	34924
	Physicia Media		1. Decedent's Name (First, Middle, La. Harry L. Heintze	,			·		2. Date of Month		y Year	3. Time of Death 12:00 P M
	Examir		4a. Facility Name (if not institution, give Suburban Hospit				4b. City, Town, o	or Location of De		4c	. County of Dea	
	Funeral Director		5. Social Security Number 434–22–4486 Usual Residence of Decedent	7. Age	(In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		in. (Month,	Birth Day, Year)	Co	thplace (State or Foreign untry) isiana
	laryland 3a-f show iffied at	Director	10a. State 10b. County DC			y, Town or Loc						10d. Inside City Limits 1
	with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 3355 Tennyson St	reet NW			10f. Zip Code 200	15		,	tizen of What Co	*
0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	ò	11. Marital Status 1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 2 Yes 2 1 If Yes, Give 2 Year or Dates 1	ቻ 3/1	943	Vas Decedent of I Yes, specify Cub	an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Ame Black, Whit Specify: Whi	e, etc.
Maryland 21215-0036	e filed within 72 hour tral Hygiene. ed other than "natul event, the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	,,	16a. Deced (Give I life. Do	ent's Usual Occu ind of work done NOT use retired gn Servi	during most of w)			ind of Business	
yland (be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Erich H. Hei	ntzen				18. Mother's N	lame (First, Midd beth Scl			
e, Mar	and 2 should Health and M em 27 is mar ther traumati			ype, Print) n / Wife		3355	g Address (Street Tennyso		W Washi	ngton,	DC 200	15
altimore,	t. Page 1 artment of hertant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)	C	emetery, cren ional	sition (Name of patory or other pla Cremator	у 10	Date /12/2012	Fall		eh, VA
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Ligen: William R. Br	MO MO	0063	5.		onsin Av	enue NW	Wash		DC 20016
5	Physician/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Myocard	ial	Infarc	,	ng, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
00	Examiner	er	Sequentially list conditions,	Due to (or as a	y Ar	tery D	isease					
120	ate be executed oblysician ages the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a								
77	icate be e p physicia as the bur		•	l d								
0/10/201 P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	P Feta	I death 3 🗌	Ectopic pregnan Other (specify)	су		-	23d. Date of de Month	livery Day Year
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ntzen, Division of	ital or Atte urs after de ral Directo	al Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify				City or	Town, State,		ral Route Number,
16,	the Hospital hin 24 hours the Funeral mpletely fillec	Medical	(Check 2 Medical Examonly one) 3 Certifying Nurs	sician: To the best of r iner: On the basis of ex se Practitioner: To the	amination	and/or invest	gation, in my opini death occurred at	on, death occurre the time, date and	d at the time, da	te and place to the cause	, and due to the (s) and manner a	cause(s) and manner stated. s stated.
	P P		29b. Signature and title of certifier	MD)		29c. Licens D679				te signed (Monti 10/2012	
			30. Name and address of person who of Yuneng Li, M.D.	8600 01d	Geor	getown		thesda,	MD 2081	. 4		
	Stat	е	31. Date filed (Month, Day, Year) 201	2 32. Registrar	's Signat	are bar	Ked.					

DHMH 17 Rev 06-2011

			State of Maryland / Dep	artment of Health and N	lental Hygie	0010	31.025				
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	Examir	ier	4a. Facility Name (if not institution, give street and number) Montgomery General Hospital		4c. County of Death Montgomery						
	Funeral Director		5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 08/12/	9. Birth Co <i>ur</i> 1935 Etl	place (State or Foreign try) hiopia				
	Maryland 18a-f shov ntified at	Director	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits				
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9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【XNo Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Black	etc.				
Baltimore, Maryland 21215-0036	within 72 ho giene. ner than "na it, the Medic.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) House	dent's Usual Occupation kind of work done during most of worki O NOT use retired) SEWIFE	ng	b. Kind of Business/In	dustry				
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imore	Page 1 a ment of H tant: If ite lury or oth		4 Donation 5 Other (Specify)	Cemetery 10/1	9/12 I	c. Location - City or To Ethiopia					
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dl	Examiner		Due to (or as a consequence of): A Chip ATTO N	PNEUMONI A							
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Division of Vital Records, P.O. Box 6876	he death certificate be executed the attending physician and ched for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year				
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Division	al or Atte s after de: il Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office	8f. Location (Street City or Town, St	t and Number or Rural late)	Route Number,				
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	E 1 2 3		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, E	Day, Year)				
			30. Name and address of person who completed cause of death (Item 23a) (Type, PASUNK KUMAR SHAKMA 151. 31. Date filed (Month, Day, Year) 15. Registrar's Signature	of Prince Philips	DE DINE	MD 20	832_				
	Stat Registra	Ç .	31. Date filed (Month, Day, Year) OCT 15 2012 82. Registrar's Signature	D.	W 7						

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Funeral		5. Social Security Nu		6. Sex	7. /	Age (In yrs.	ast birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bi			g. Birth	place (S	tate or F	oreign
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Medical Examiner		resulting in death)		ſ	Due to (or a	is a conseq	uence of):	416										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 2012 Physician/ 1605 Mariam J. Holden Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury <u>Peninsula Regional</u> Med Ctr Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Funeral (Month, Day, Year) Hours Director 225-32-9811 Usual Residence of Decedent 1 □ M 2 🔯 F 83 11-22-1928 VA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Withams Accomack 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 23488 35058 Neal Parker Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: SpeciBlack 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Poultry Industry Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula Hinmon Adolphous Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 230 Amberliegh Dr, Silver Springs, MD 20905 Lyle Holden, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Jerusalem Bapt Cemi10-14-2012 Temperanceville, VA 4 ☐ Donation 5 ☐ Other (Specify) 82. Name and Address of Facility 917 W. Isabella St. Bennie Smith 21. Signature of Funeral Service Licensee Home Salisbury, MD 21801 Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Cardiac Physician min Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopath ears Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consuluence of: ear5 pertension the attending physician and ched for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Diabetes ears Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death sate has been signed by the a page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) (2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nd title of certifie 29d, Date signed (Month, Day, Year) 29b. Signatu 29c. License number 10-09-2012 14-0070020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pocomoke MD 21851 Market Street Suite 500

State

Registrar

31. Date filed (Month, Day, Year)

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2012

Registrar's Signature

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		For State	State of M	larylan	*	artment of H		d Mental Hy	/giene	e 0.01	0 010	0 0
		Registrar 1. Decedent's Name (First, Middle)	[ast]		Ce	ertificate of L	<i>Jeath</i>	2. Date of D	Reg. N	0.	2 349	28
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Examin	er	4a. Facility Name (if not institution,				4b. City, Town, or		eath	40	c. County of De	ath	
Funeral		16530 Steele Ro 5. Social Security Number	6. Sex 7. Ac	e (In yrs. I	ast birthday)	Henders If Under 1 Year	SON If Under 24 H	Irs. 8. Date of Bi	rth	Caroli	irthologe (State or For	eian
Director		029-20-9672 Usual Residence of Decedent	1 🗆 M 2 🔀 F	84	Yrs.	Months Days	Hours M		3 ^{y,} Year)	27	Virgini	a
shov d at	tor	10a. State 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Lin	nits
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of He of He if iten	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Demonstrate Chate	20b. F		osition (Name of ematory or other place	e)	Date	20c. L	ocation - City	or Town, State	
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permit Depart Impor any in		21. Signature of Funeral Service Li	icensee		2	2. Name and Addres	ss of Facility P	Box 160	; G1	reensbo	ro, MD	
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Medical Examiner		resulting in death)	Due to (or as	a consequ								
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check / 2 Medical Ex	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	xamination	and/or inves	stigation, in my opinic	n, death occurre	ed at the time, date	and place	e, and due to the	cause(s) and manner s	tated.
Voit Voit		29b. Signature and title of certifier	1 1 0			29c. License	number		29d. Da	ate signed (Mon	th, Day, Year)	
		father 14	in tople			H0057	0873		Oct	toher,	18, 2012	
		30. Name and address of berson w	ho completed cause of d	leath (Item			122 Gul	debra us	2 /	636		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth C. Harding 0508 <u>2</u>012 October 0 0 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Cambridge 2625 Rebecca Lane 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours 215-20-4226 Director 1 M 2 1 F 88 March 12,1924 Pennsylvania r then "natural", or items 23a or 28e-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f shoinly injury or other treumetic event, it as Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits Director Cambridge Dorchester 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21613 2625 Rebecca Lane Was Deceue...
Armed Forces?
1 Yes 2 No
14 Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hurlock Sportswear Seamstress 11-Graduate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Workman ည Kenneth Lee Cordrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2625 Rebecca Lane, Cambridge, MD 21613 19a. Informant's Name/Relationship (Type, Print) Constance Swafford/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cokesbury, Maryland 10/15/12 Cokesbury Cemetery 22. Name and Address of Facility Framptom Funeral Home, P.A. Signature of Funeral Service Licenses PElocele 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on parth line. Approximate Interval Between et and Death Immediate Cause (Final Physician disease or condition resulting in death) YELTS Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the buriel-transit To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificale has t een signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the buriel-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: Set the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: Set the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 408 B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Funeral Director		5. Social Security Number
Director		215-96-1246
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Baltimore, MD 21215-0036 bermit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. Cou
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens and the statural?, or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Elementary/Secondary (0-
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7. Important: Witem 77 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical	1	
and 2		Ronald F. H. 20a. Method of Disposition
Ore of H If it		1 Burial 2 X Crema
Pag Pag ment		4 Donation 5 Othe 21. Signature of Funeral Sen
Salt rmit. epart poor jury		21. Signature of Funeral Sen
		Kathleen San
Physician		23a. Part I. Enter the disease failure. List only one ca
Examiner		Immediate Cause (Final dise
Lammer		or condition resulting in deat
		Sequentially list conditions,
	i e	if any, leading to immediate cause. Enter Underlying Ca
	am	(Disease or injury that initiate events resulting in death) La
nted d ansit	ted by Physician/Medical Examiner	events resulting in death) Le
is, P.O. Box 68760, quires that the death certificate be executed en signed by the attending physician and ald be detached for use as the burial - transit	ical	X UNPENDED
50, te be iysici	led	IF FEMALE:
876 tifica ng ph	1	23b. Was decedent pregnant
h cer tendi	Cia	past 12 months?
Bo deat the at for	nys	1 Yes 2 No 9
d by	4	Part li. Other significant co
res th	Q P	
ds requirequi	ete	
COI law has t	ld I	
The The	ပ္ပြဲ	
tian: certif ector,	Be	25. Was case referred to med examiner?
this al dir	ဂ္ဂ	1 ✓ Yes 2 No
Division of Vital Records, P.O. Box 68760, to or Attending Physician: The law requires that the death certificate be an order death. In Director: After this certificate has been signed by the attending physical bir to be the funeral director, page 2 should be detached for use as the but	Ë	27. Manner of Death
ior tend leath.	ație	1 Natural 5 F
ViS or At fler d Direc in by	ific	3 Suicide 6
pital Di	ě	4 Homicide
Hosy 24 ho Funk tely f	a	29a. Certifier 1 CertifyIn
Division of Vital Records, P.O. Box 68760, To the Boptial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	//edical Certification: To Be Comple	one) 2 Medical
8 1 8 1	8	29b. Signature and title of ce

Benjamen Andre	ew H	fillard State of Maryland / Department of Health and Ment						
		1- For State Certificate of Death Registrar		eg. No. 201	2 3493			
Physici	an/;	Decedent's Name (First, Middle,Last)	2. Date of Deat	h	3. Time of Death			
Medical Exami	ner	Benjamen Andrew Hillard	Month October 2		1010 hrs			
	Principal desired	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 45994 Clarks Rd California	of Death	4c. County of Death St. Mary's				
Funeral	h	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs. 8. Date of Birt	h (MM/DD/YYYY) 9. Birt				
Director		215-96-1246 1 M 2 F 48 Yrs. Months Days Hours	Min. 09/16,	/1964 Foreig	ⁿ ^{Untry} Virgin <u>ia</u>			
		Usual Residence of Decedent	05/10/	71504				
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No			
yland n-f she	횼	Maryland St. Mary's California 10e. Street and Number 10f. Zip Code	I 10	og. Citizen of What Cour				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fahow a injury or other traumatic event, the Medical Examiner must be notified at once.	Director							
with ti	펻	45994 Clarks Road 20619 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Conference of the Conference of Hispanic Original Conference of the Conference o	in? (Specify Yes or No-					
death ir iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, 1 Yes 2 X No	Puerto Rican, etc.)	White, etc.				
after		3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: or Dates:		Specify: Whi				
hours "natu	te d	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		16b. Kind of Business/I	ndustry			
36 thin 72 than edical	힅	1 Salesman		Automotive	Parte			
5-0036 iled within 72 Hygiene. d other than	Completed by		s Name (First, Middle, M		Tares			
2121 2121 ould be fil Mental F marked ic event,	B		ne Morris					
D 2. should and M 7 is m	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb						
, MD and 2 sho tealth and tem 27 is	-	Ronald F. Hillard/Father 45994 Clarks Road, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	California Date	a. MD 2061 20c. Location - City or				
Baltimore, permit. Pages l ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	10/0//0010					
iltirr ait. Pa artmei oortan	ŀ	4 Donation 5 Other Specify: Brinsfield-Echols Cre 21. Signature of Funeral Sergioe Licensee: 22. Name and Address of Facility						
Dep Dep		Rathleen Santivasci M00872 22955 Hollywood	Brinsfield Road, Leon	Funeral Honardtown, M	me, P.A. D. 20650			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and			
Examiner	ı	Immediate Cause (Final disease a. Complications of morbid obesity			Death			
	- 1	or condition resulting in death) Due to (or as a consequence of): b.						
	直	if any, leading to immediate Due to (or as a consequence of):						
	a E	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			ļ			
executed an and al - transit	ical Examiner	d						
<u> </u>	dica	■ MENDED 23a,27,per me,g933 11-20-12	sm					
Box 68760, death certificate be. the attending physiciate for use as the burit	/Me	IF FEMALE: 23b. Was decedent pregnant in the 2ctopic 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of delivery Month D	ay Year			
x 68 h certi tendin	icial	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	programoy	Monar	ay rour			
BO) ne death the att	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	Loo Bill		harran of death O			
3, P.O. Be interest that the dear signed by the state of	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	1 Yes	bacco use contribute to to 2 No 3 Prob	ably 4 duknown			
Division of Vital Records, P.O tal or attending Physician: The law requires that it as after death. In Director: After this certificate has been signed by let fineral director, page 2 should be detaged.			24a. Was a	24a. Was an 24b. Were autopsy findings available				
Cords, law require has been s	Completed		autops	med? death?	ompletion of cause of			
tal Rec		25. Was case referred to medical 26.Place of Death (1 Yes 2	2 No 1 ✓ Ye	s 2 No			
Vital ysician: his certifi director,	To Be	examiner?		Residence 6 🗸 Other	Scene			
Of Viing Physical After this	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		ow injury occurred				
SiOn ttend death. ctor: y the f	atio	2 Accident Investigation						
Division of ' pital or Attending Ph ours after death. erral Director: After t filled in by the fineral	Certification:	3 Suicide 6 Could not be determined (Specify)	28f. Location (S or Town, St	treet and Number or Ru tate)	al Route Number, City			
.g. ≥ .g .		4 Homicide 29a. Certifier 1 Cartifular Physicians To the best of my knowledge, death accurred at the time date and play	ce, and due to the cause	e(s) and manner as state	ed.			
To the Hor within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate one) and manner stated.						
5.35.8	Re	29b. Signature and title of certifier 29c, License number		29d. Date signed (Mor	th, Day, Year)			
6		Court 1) O.C.M.E.		October 22, 2012				
BA		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	more MD 21222					
	ate	31 Data filed (Month Bushlends as 22 Registrat's Signature #	11016, WID Z 1223					
Regist	trar	31. Date filed (Month, OCT at 2 5 2012 32. Resistrar's Signature S. Jacks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mp0th 1-2012 Day Kelvin C Hines 9:30PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 212-82-0823 1 🕅 M 2 □ F Yrs 51 8-3-1961 Washington DC Usual Residence of Deceder 28a-f shov 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director Md Prince George's Capitol Heights 1X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4904 Gunther Street 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 6 Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Completed If Yes. Give 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry 2 should be filed within 72 h th and Mental Hygiene. 77 is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Handyman Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Hines Sarah Campenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a Item 27 i Derick Hines, Brother 1220 7th Street NW #301 Washington DC 20001 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If Ite any Injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation →□ Removal from State Mt Zian Cemetery 10/9/2012 Baltimore Maryland 4 Donation Other (Specify 21. Signature of Fund al Service Lice 22. Name and Address of Facility Ronald M Taylor 11 Funeral Home 1722 North Capitol Street NW Washington DC 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Dnset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed physician and s the burial-transit Cause (Disease or injury that initiated events 1LURS 70 THRIVE Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 use as attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has perform 1 Tes Yes 2 Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No P 1 Inpatient 2 ER/Dutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this. 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the letely filled in by the funera Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Ccident 5 Pending 1 🗌 Yes 2 🗌 No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner, 70 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signat 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) ereon who completed o ame and address of r 7503 SURRATTS State Registra

DHMH 17 Rev 06-2011

Division of Vital

		1	For State	State of M	aryland / De	epartmer Certificat			and M		/	2012	21.032
			Registrar 1. Decedent's Name (First, Middle, La	st)		erincal	9 01 0	eaui	T	2. Date of De	Reg. No.	2012	3. Time of Death
	Physicia Medic		Melvin Eugene Hu					_		October	10,20	12 Year	3:25 p _M
	Examin		4a. Facility Name (if not institution, given 12005 Rousby Hal			4b. City, Lus l		Location of	of Death			County of Deat Calvert	th
	Funeral Director			Tex 7. Ag	ge (In yrs. last birthd 64 Yr	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir July 3,			thplace (State or Foreign
	land show dat	o.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Limits
	Maryli 28a-f otifiec	irect	MD Calvert		Lusby								1 Yes 2 No
	ith the 23a or st be n	ral D	10e. Street and Number 12005 Rousby Hal	Road		10f. Zip	Code 0657				10g. Citiz	zen of What Co	ountry?
	eath w tems ? er mus	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Deced	dent of His	spanic Ori	gin? (Spec	ify Yes or No-		4. Race - Ame	
20	after d	d by	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give	No	1 Yes				,	8	Black, Whit Specify:	Black
5	hours nature Jical E	ete	15. Decedent's (Specify only highest g		16a. D	ecedent's Usu Give kind of wo	al Occupa	ation	t of workin	a	16b. Kir	nd of Business	
121	thin 72 me. than " the Mec	Completed	Elementary/Secondary (0-12)	College (1-4 or	lif	e. DO NOT us	retired)			Repaire	Fed	eral Gov	rernment
N N	should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is markled other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,	Maiden S	urname)	
ylar	lid be f Menta narked atic ev	은	Willie Henry Huds	on 				Zadı	ie Pea	rl Murph	ıy —		
Baltimore, Maryland 21215-0036	C4 ± 64 ±		19a. Informant's Name/Relationship (Odessa T. Hu	Type, Print) dson - daug 	hter 19b. M	Aailing Addres 7900 Re	Street a	Courl	Fred	Route Numbe Pricksbu	r, City or rg, VA	70wn State Zi 22407	ip Code)
lore,	ge 1 and nt of Heal : If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of D	isposition (Nai crematory or c	ne of other place	eterv		ate 19, 2012	l	cation - City or litchell, A	
iii iii	permit. Page 1 ar Department of H. Important: If ite any injury or oth		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice			22 Name a	nd Addres	s of Facilit	tv Sev	vell Fune	ral Hon	ne, P.A.	
Ba	Dep Imp any		Dladen a. x	ewell		1451	Dares	Beach	n Rd. F			k, MD 206	678
	Medical Examiner	er.	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	d the death. Do not not not not not not not not not no	hea	C T	g, such as Jac yopa	leer Llvy	respiratory a	rest,		Approximate Interval Between Onset and Death
09	ate be executed hysician and the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for as	Verteurs a consequence of)	ree 1	Rea	nt	Dis	ease			
Box 687	death certifics ie attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death at time of death	3 Ectopic 5 Other (s		су			2	23d. Date of de Month	alivery Day Year
s, P.O.	ires that the signed by the signed by the details and the details and the details are the signed by	by	Part II. Other significant conditions Davies	contributing to death		the underlying	cause giv	ven in Part	I.				o the cause of death? Probably 4 🗆 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed								1 \(\text{Yes}		prior to death?	utopsy findings available completion of cause of es 2 No
lta	sician: certifi lirector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 - ER/Outp	actiont 2 🗆 🗆	Othe	ace of Dea			idanaa 6	Other (Spe	cita)
ot o	ig Phy: ter this neral d	te: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of inj	ury 28b. Tir		28c. Injury work	y at		28d. Describe			Ciry)
lon	tendir Jeath. tor: Af the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not	on he		М	1 🗆	Yes 2		206 1 + i	/C+++++	d Number or D	ural Route Number,
)ivis	al or At s after of Directed in by		4 Homicide determine		jury - At home, farn tc. <i>(Specify)</i>	i, street, ractor	y, onice				wn, State)		arai noute Numba,
_	Hospita 24 hours Funeral etely fille	Medical	(Check 2 Medical Exar	ysician: To the best on niner: On the basis of rse Practitioner: To t	examination and/or i	investigation, in	my opinio	on, death o	ccurred at	the time, date	and place,	and due to the	cause(s) and manner stated.
	To the vithin To the complete	2	29b. Signature and title of certifier	/	222 Of thy Known	29	c. License	e number	2	,		e signed (Mon	
	110		1	gover	10			288			· ·	0112	11.5
	KW 1		30. Name and address of person who	ASL M	D 22	pe, Print)	n SE	qua	ne i	rl	usby	Md	20657
	Sta Registr		31. Date filed (Month, Day, Year) OCT 15 2012	Dengua 32. Regist	rar's Signature	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Marian Ellen Hutchins Physician/ October 12 2012 a 10:55 PM Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick 4480 Diane Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days Min 1 🗆 M 2 🗶 F 1271171940 Washington, DC 71 Director 212-38-3749 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Prince Frederick Maryland Calvert 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 20678 4480 Diane Court items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12, Was Decedent Ever in U.S. Armed Forces Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 XNo 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thomas Edmund Carrick Daisy Mae Lohman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is r. any injury or Attach / Husband 4480 Diane Court, Prince Frederick, Maryland 20678 Chester Wood Hutchins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitian Crematory 10/16/2012 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, 21. Signature of Funeral Service Licensee 4405 Broomes Island Rd.,Port Republic, MD 20676 M01206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ NEW disease or condition resulting in death) Medical Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (ar as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) _____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death ed by the a detached f g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an WCMI has autopsy page perform certificate 1 Yes Yes 25. Was case referred to medical examiner? Division of Vital After this certific funeral director, 26. Place of Death (Check only one) Be Hospita 2 🗆 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No neral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Funeral [Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Day, Year) 29c. License number 0 0 (Item 23a) (Type, Print) person who completed cause 239 Morrimac State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland / [and Me	ental Hy	giene	2012	01001
		-	Registrar 1. Decedent's Name (First, Middle, Last)			Certifica	ite of L	peatn		2. Date of Dea	Reg. No₁	ZUIZ	34934
I	Physicia Medic		Thelma Irene H	untzberry	I					Month Octobe:	Day	2012	3. Time of Death 11:35 PM
~ \	Examin		4a. Facility Name (if not institution, give stre			4b. Ci	ty, Town, or	Location			_	County of Death	
أمر			In God's Care Assis				. Lec					alvert	
	Funeral Director		5. Social Security Number 6. Sex 212–26–1391 1 🗆	7. Age (M 2 ⊠ F	In yrs. last birt. 98	Month	der 1 Year s Days	If Under Hours	Min.	8. Date of Birt (Month, Day	, Year)		hplace (State or Foreign intry)
			Usual Residence of Decedent			Yrs.			. (03/29/	1914	Mary	yland
	rylanc I-f sho ied at	Director	10a. State 10b. County		10c. City, Towr								10d. Inside City Limits
	ne Ma or 28a notif	Dire	Maryland Calvert 10e. Street and Number		St. Le		Zip Code				10- 01	zen of What Cou	1 Ves 2 No
	with the 23a of 1st be	Funeral	2365 Delight Court				0685					ted Sta	
	tems er mu	Fun		Was Decedent Eve	er in U.S.	13. Was Dec	edent of His			fy Yes or No-		4. Race - Amer	
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at , the Medical Examiner must be notified at	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0		2 🔀 No		n, Puerto Ri	can, etc.)		Black, White Specify: Wh	
9	ours a atural cal Ex	Completed	3 M Widowed 4 □ Divorced 15. Decedent's Education	Year or Dates.	160								ite
215	n 72 h an "n Medi	ldm	(Specify only highest grade Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry		
21	withii giene ner th t, the		12	College (1-4 or 5+)		Nurse	2				Неа	alth Car	re
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Ma	12 shouth and the sho	1	Ray Woodrow Huntzberry,			. Mailing Addre 315 Pisc a						Town, State, Zip	Code)
re,	1 and 2 s of Health item 27		20a. Method of Disposition		20b. Place of	Disposition (A	ame of		Da			cation - City or 1	Town, State
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 M Burial 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		y, crematory o. Lill Ceme		1	10/13/2	012	Brook	dvn Park.	, Maryland
3alt	permit. Departimont Import any inj		21. Signature of Funeral Service Licensee			22. Name	and Addres					ome, P.A.	
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	A RECORD FOR THE		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final	ause on each line.			, ,	1	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	Due to (or as a		NSC LU	or c	كيلا	CCISC	2_0			4 days
	Examiner			Duc 10 (01 23 2 C	onsequence e								ì
	- +	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence o	f):							
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	ite be executed hysician and the burial-transit	dical E	resulting in death) Last	Due to (or as a c	onsequence o	T):							
760	icate l	edic	d. ,										
89	eath certificate attending phy of for use as th	N/N	Zob. Was decedent pregnant	If yes, outcome of		2 D Fatani					2	3d. Date of deliv	very
Box 687	death	Physician/Me	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at ti 9 Unknown		5 Other		· · · · · · · · · · · · · · · · · · ·				Month	Day Year
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ord	requi	Completed	Diabedy Me	111.2				_		24a. Was a			opsy findings available
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a F	ian: T		25. Was case referred to medical examiner?				26. Pla	ce of Dea	th (Check or	1 Yes	2 La No	1 L Yes	2 □ No
₹	hysic his ce al dire	욘	1 Yes 2 No	1 Inpatient	t 2 🗆 ER/Out	patient 3	DOA Other	r: 4 🗆 Nı	ursing Home	e 5 🗆 Resid	ence_6[X Other (Specif	y Assisted
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Siol	Attendi death. ctor: A yy the fu	rtific	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, far	m street facto		Yes 2□		f Location (S	troat and	Number or Pur	al Pauta Number
Division of Vital Records, P.O.	al or / s after il Dire		4 Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ny, omeo		20	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending planting to completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner:	n: To the best of my	knowledge, o	leath occurred	at the time,	date and	place, and	due to the ca	use(s) and	d manner as sta	ted. ause(s) and manner stated.
	thin 2, the F the F		only one) 3 LX Certifying Nurse Pr	actitioner: To the b	est of my know	ledge, death o	curred at th	e time, da	te and place	, and due to th	ne cause(s) and manner as	stated.
	⊼ i≥ 6 2		29b. Signature and title of certifier	COIN			RI34			j		signed (Month,	
		}	30. Name and address of person who comp	lated cause of deep	th (Item 23a) (T	iron Drint)		100				10-301	d
di	(W 6	ŀ	Tiffciny Caines 412	Coldle	with ing	in Ral	wal	elor	CM)	9000	2		
	Stat	~	31. Date filed (Month, Day, Year)	32. Registrat's	Signatura				-				
	Registra	r	06111	UIL Len	wa ,	a. spa	Ke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34935 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 10/08/2012 Physician/ Rose H. Hirschy 900 P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rock Spring Village Harford Forest Hill 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 222-05-6217 6/26/1920 Director 1 □ M 2 🛛 F Delaware 92 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at with the Maryland Director Maryland Harford Aberdeen 1 X Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 638 Brenda Lane Funeral 21001 U.S.A. items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dean Department of health and Mental Hygiene.
Important If item 27 is marked other the any injury or other traumany. Examiner Armed Forces?

1 ▼ Yes 2 □ No
If Yes, Give
Year or Dates. ₩₩Ⅱ Black, White, etc. þ 1 Never Married 2 Married 1 🗌 Yes 2 💢 No Specify: Specify: White Completed 3X Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care Be Father's Name (First, Middle, Last)
John Smith 8. Mother's Name (First, Middle, Maiden Surname) Kathrina Monak 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Timber Trail, Wethersfield, CT 06109 Patricia Hirschy (daughter) 20b. Place of Disposition (Name of Aberdeen, 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harrord Mem Gons 10/13/12 Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St, Havre de Grace, 23a. Part 1. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ eines ak disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No Month Day Year signed by the at Id be detached fo 1 Yes 2 4 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner Hospital Other: 4 Nursing Home 5 Residence 6 Other (Se 1 🗌 Yes 2 PNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniun 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

address of person who completed cause

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:30 A Month Marie Heslin 20Ï2 Medical 4a. Facility Name (if not institution, give street and number)
Stella Matis 4b. City, Town, or Location of Death **Timonium Examiner** Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)

New York **Funeral** 110-26-8057 Hours 79 **Director** 1 □ M 2 🗗 F 10/2/1933 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baldwin 1 Yes 2 No Md. Harford 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral U.S.A. 2713 Park Heights Drive 21013 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home House wife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rhuben Wesley Pettingill Mary Monaghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 Park Heights Dr. Robert F. Heslin, Baldwin 21013 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Carrella Cremation 10/10/12 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hampstead, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. P.O. Box 6 Jarrettsville, Md. er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical DEMENTI resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events CTOBER Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for Month Year Pregnant at time of death 1 Yes 2 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by liseus 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy perform ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 2 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury accurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 2 Accident injury 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

Registrar

31. Date filed (Month, Day, Year)

OCT 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ ror	partment of Health and N	/lental Hygie	ne	01 007	
			State Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	No.2 U L	34937	
П	Physicia		Bessie S. Jacobsen			11, 2012	3. Time of Death 3:26 AM	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4c. County of Death			
-e ^t			428 Girard Street, #T4	Montgomer				
1	Funeral Director		5. Social Security Number 219–34–9595 6. Sex 7. Age (In yrs. last birthda	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. Feb. 5.	ar) Coui		
	d ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		105. 5.	New	Jersey	
	arylan a-fsh ified a	Director	Maryland Montgomery Gaither				10d. Inside City Limits 1 ☐ Yes 2 🕱 No	
	the M		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?	
	n with	Funeral	428 Girard Street, #T4	20877	Ur	i <u>ited Stat</u>	es	
	r deatl or iten iiner n		Armed Forces? 1942	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,		
920	rs afte Iral", c Exam	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: Wh	ite	
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ylaı	Menta Menta narked	유	Barnet Schwartz	Sarah Fi				
Maryland 21215-0036	2 shot th and 27 is n traum	1	1 1 2 2	ailing Address (Street and Number or Rura ${\sf 6}$ ${\sf Chestnut}$ ${\sf Street},$				
re,	1 and 2 s of Health item 27 other tra		20a, Method of Disposition 20b, Place of Dis	position (Name of	Data 200	c. Location - City or T		
imo	Page ment c ant: If ury or		1 🔀 Burial 2 □ Cremation 3 🛣 Removal from State 4 □ Donation 5 □ Other (Specify) Ceme	epanon :	per 14, Is	selin, New	Jersey	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Suneral Service Ligenses	22. Name and Address of Facility De 10 E. Deer Park Dri		•	MD 20877	
		- 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not e			lersburg,	Approximate	
. 1	hysician/	E 21	hock or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia disease or condition				Interval Between Onset and Death	
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	- 180 T	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):					
	auth certificate be executed attending physician and I for use as the burial-transit	Examiner	that initiated events c.					
_	oe exelician a	alE	resulting in death) Last Due to (or as a consequence of):					
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Box 68760	h certii tending	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deliv		
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P.O.	requires that the des been signed by the s should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
ds,	quires en sig ould b				1 🗆 Yes	2 X No 3 □ Pro	obably 4 Unknown	
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l Re	rsician: The law i certificate has b director, page 2 s		25. Was case referred to medical	OC Disease Death (Observed)	performed		2 🗆 No	
Vita	ysician s certii directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Chec		e 6 Other (Specif		
of	iing Physician: The la n. After this certificate ha funeral director, page		27. Manner of Death 1	of 28c. Injury at	28d. Describe how i		,	
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Division of Vital Records,	al or A s after I Direct		4 ☐ Homicide determined building, etc. (Specify)	street, factory, office	City or Town, S	n (Street and Number or Rural Route Number, Town, State)		
—	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in	estigation, in my opinion, death occurred a	t the time, date and p	lace, and due to the ca	ause(s) and manner stated.	
	orthe	M	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier		ace, and due to the ca		stated.	
	F F O		1 (16henr	D37142	00	tober 11,	2012	
			30. Name and address of person who completed cause of death (Item 23a) (Typ Geoffrey Coleman, M.D., 1355 Piccard		Rockvill	.e, MD 208	50	
	Stat			all				
	Registra	ar	OCT 12 2012 Jerus B. A					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 10 aa15 Jones atoya 10 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Head Wicomico Jeers If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) ge (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🖫 F Months Hours Min. 219-08-4846 MD Director -98 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No Funeral Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 135 First Street 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Spec Black Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 PRMC Day Care ilth and Mental Hygier 27 Is marked other the r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roland Jones Ageranna Jones ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Parents Health a MD 21801 135 First St, Salisbury, item 27 other to Roland & Ageranna Jones 20b. Place of Disposition (Name of cemetery, crematory or other plate), 20c. Location - City or Town, State 20a. Method of Disposition of 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or ± 6 Cremation, 10-16-2012 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Beinie Smith 917 W. Isabella St. Funeral Home Salisbury, MD 21801 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 11 Dulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** infoc sions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed avoxicen the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by filled in by the funeral director, page 2 should be DILLUMN GC1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☑ No epsis Dus 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNO 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 24 hours after death. Funeral Director: A investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1030. 10 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) Schae 5 Scha 32 Registrar's Signatu DEAR'S HEAD MD. State

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 8:50 A Tommy Lee Justice 0 5019 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner Wicomico 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** VA Country) 1**X** M 2 □ F Months Min 3-23-1949 63 **Director** 223-62-6431 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Tes 2 X No Pocomoke MD Worcester 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be I Funeral 21851 1210 Market Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 \sum No Army Black, White, etc. þ 1 XNever Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify:Black 「OM AUS上に Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 1975 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Laborer Seafood Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ any injury or other traumatic Stanford Justice Winny G. Wharton permit. Page 1 and 2 should Department of Health and Mo Important: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Justice/Sister 517 Bay St, Apt A6, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Jerusalem Bapt Cem10-13-2012 Temperanceville,VA Fennie and Address of Fedlity 917 W. Isabella St. 21. Signature of Funeral Service Licenses Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Months S Immediate Cause (Final Physician/ Laryngeal disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an e Hospital or Attending Physician: The law 1 124 hours after death. e Funeral Director: After this certificate has b autopsy performed Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: Other: ျှ 1 Yes Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H68413 Oct 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 1733 Salisbury, MD 21802 Funaioli-Sheehan D. 6.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

15

12-07883 John Pitt Jordan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Iohn Pitt Jordan	1- For State	ate of Maryla		artment of		Mental H		eg. No. 21	012 3494
Physician	Registrar 1. Decedent's Name (First, Middle)	le,Last)					2. Date of Deat	h	3. Time of Death
Medical Examine		rdan					Month October 18	Day Year 8, 2012	0637 hrs
	4a. Facility Name (if not institution		nber)	4	o. City, Town, or L	ocation of Death)	4c. County o	f Death
* '	Civista Medical Cente				LaPlata			Charles	
Funeral	5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min		th(MM/DD/YYYY)	9. Birthplace (State or Foreign Maryland Country
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Hygie of the N		Last)			18	B.Mother's Name	(First, Middle, N	/laiden Surname)	
21215-0036 Mottal Hygiene marked other than "natural", or items 23a or 28a-f sho e event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	John Pitt Jordan, Sr Donna Lynn Blackwell								
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ore, MD s: 1 and 2 sho of Health and of item 27 is nor traumati	Donna L. Mende 20a. Method of Disposition	z/Motner_	20b. F		on (Name of ceme		Date Na		MD 20601 City or Town, State
Baltimore, permit Pages 1 an Department of He. Important: If ite	1 X Burial 2 Cremation	3 Removal fro	m State	crematory or other					
t. Pay	4 Donation 5 Other Sp 21/Signature of Funeral Service		Que	en of P	eace Cem	. 10	/24/2012	Helen,	Maryland F.H., P.A.
Baltimore, MC permit Pages 1 and 2 s Department of Health at Important: If item 27 injury or other trauma		12 /	TE MOC	2017 201	O.E. There are	N-4-1	nstield.	-Echols	F.H., P.A.
Physician	23a. Partyl. Enter the disease, or	complications that ca	used the death.	Do not enter the	mode of dying, s	uch as cardiac o	r respiratory arre	est, shock, or hea	rt Approximate Interval
/Medical	failure, List only one cause	on each line.							Between Onset and Death
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). Box 68760 the death certificate by the attending physiched for use as the buPhysician/Met	IF FEMALE: 23b. Was decedent pregnant in the		utcome of pregr			Ectopic pregna		23d, Date of	delivery Day Year
ox 687 eath certification attending if or use as t	past 12 months?	I I Elve bi	πn ant at time of dea	ath -	I death 3 _ er (Specify)	ctopic pregna	al icy	Month	Day real
Box e death the atte ed for y	1 Yes 2 No 9 Unk	known 9 Unknor	wn	o E Our					
P.O. es that the greed by t		ions contributing to	death but not re	esulting in the un	derlying cause giv	ven in Part I.			oute to the cause of death?
s, P.C ires that i signed i be deti									Probably 4 Unknown
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Records, The law require, fricate has been sign, page 2 should by Completed	5						perfor 1 ✓ Yes		eath? ✔ Yes 2 No
ital Recieian: The laction to the lactor, page	25. Was case referred to medical		-2-0			of Death (Check			
Physici rr this o	examiner?	Hospital: 1 lr	npatient 2	ER/Outpatient	3 DOA	other Mursin	ng Home 5	Residence 6	Other:
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ision Attend ar death. rector: by the f	Natural 5 Pend 2 Accident Inves	stigation I Q IU		unknown		es 2 🗓 No	unknow		
Division of Vital Records, spital or Attending Physician: The law require tours after death. neral Director: After this certificate has been sirefiled in by the funeral director, page 2 should be Certification: To Be Completed	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined (Specify) A Residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4208 Quigley Ct.								
Divi		(Waldorf	,MD.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by Medical Certification: To Be Completed by Physician/Me	(Check only 1 Certifying Plone) 2 ✓ Medical Example (Check only 1 Certifying Pl	hysician: To the best miner:On the basis o							
To T vith To T com	29b. Signature and title of certifie	and manner st			29c. License				d (Month, Day, Year)
	PANAD	411	OA in		O.C.M	I.E.		October 19	
	30. Name and address of person	who completed cause	e of death (Item	23a)				<u> </u>	
		Assistant Medic			altimore Stree	et, Baltimore	, MD 21223		
	(a 31. Date filed (Month, Day, Year)		gistrar's Signatu	ber	1.1				
Registra	0CT 2.5	7017 1/4-	MARIA G	7. ANGLI					

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
State
Registrar Amend #16B Per FH JM 10 Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OH NSON Physician/ SSE Month / O 04 ZUL 0120 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5, Social Security Number 431-76-4127 **Funeral** 71 **Director** 1 XM 2 □ F Arkansas 7/22/1941 28a-f shov 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Upper Marlboro 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13202 Muscouy Ct. Funeral 20774 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) grigulture gricultu Elementary/Secondary (0-12) College (1-4 or 5+) Federal Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Johnson Pearlie Mae Slack permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Strickland/daughter 13202 Muscouy Ct. Upper Marlboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place 10/12/12 Cheltenhem, MD Cheltenhem Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NE Washington DC 20019 MO1388 Dunn & Sons-5635 Eads St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months? Month Pregnant at time of death Day Year signed by the at d be detached for Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Page 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy 2 No Yes funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 - No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 5,5m nsEHWY

Registrar

DHMH 17 Rev 06-2011

State

Registrar's Sign

12-07843 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Colleen Kenney State of Maryland / Department of Health and Mental Hygiene 2012 34942 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3 Time of Death Month Day October 16, 2012 0907 hrs Medical Examiner Colleen Theresa Kennev 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min Foreign Director 32 1 M Pennsylvani 2 **X** F Yrs /29/1980 78-66-6541 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Harford Fallston MD. Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant! If item 27 is marked dother than "natural", or items 23a or 23a-f she or other traumatic event, the Medi all E-miner must be notified at once Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3205 21047 United States Canterbury Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department Itimore, MD 21215-0036 12 10 Statistician of Defense 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be P. Kenney McTague William Christine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Jaszewski (Husband) 3205 Canterbury Lane Fallston, MD. 21047 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Oct. 18, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Hampstead, Maryland Donation 5 Other Specify Cremation larrol 22. Name and Address of Facility 21, Signature of Fugeral Ser E.G. Kurtz & Son Funeral Jarrettsville. 23a. Part I. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Pulmonary Thromboemboli Immediate Cause (Final disease Èxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical x AMENDED#1,23a,27,per me,g934 12-12-12 sm X UNPENDED attending physician or use as the burial -The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? director, page 2 this certificate Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical æ Other Nursing Home 5 Residence 6 Other: DOA 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 17, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 2. Registrar's Signature arked

Registra

OCME

Medical

within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Examiner

Medical Certificate: To Be Completed by Physician/Medical

Physician/

Medical

Examiner

Funeral

Director

29b. Signature and title of certifier

Director

Funeral

Completed by

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Please '	Type or Prin						-		Legil	ble.
For State	State of Ma	ryland / I		artment of tificate of		and M		-		
Registrar 1. Decedent's Name (First, Middle, Last)			Cer	inicate of	Dealli		2. Date of De	Reg. No.	20	2 3. Tige of Death S
Larry D. Kant							Month Octobe	Day	20	Year
4a. Facility Name (if not institution, give s				4b. City, Town,	or Location of	of Death		\neg	County of	
Bethesda Health an				Beth						omery
5. Social Security Number 6. Sex 1 五 5 1	7. Age ☐ M 2 ☐ F 5	(In yrs. last birt 7	hday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birl July 23		55	9. Birthplace (State or Foreign Country) Illinois
Usual Residence of Decedent							- July 23	, 1)	<i></i>	TITINOIS
									10d. Inside City Limits	
MD Mon	tgomery	Sí	.1ve	r Sprin				10 000		1 Yes 2 XXIIo
1124 Dennis Ave				1 '	901			10g. Citi	USA	hat Country?
	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of	Hispanic Ori	gin? (Spe	cify Yes or No-			- American Indian,
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ♣ N	lo		Yes, specify Cu	,	•	Rican, etc.)			, White, etc. White
3 Widowed 4 Divorced	If Yes, Give Year or Dates.									
15. Decedent's Edu (Specify only highest grad	le completed)		(Give k	ent's Usual Occi kind of work don O NOT use retire	during mos	t of worki	ng	16b. Ki	nd of Bus	siness Industry
Elementary/Seconday (0-12)	College (1-4 or 5+)	Che	_	<u> </u>			 Rest	aura	nt
7. Father's Name (First, Middle, Last) Hans Georg Kant					i		e (First, Middle, fa Pick	Maiden S		
19a. Informant's Name/Relationship (Typ	e, Print)	196	. Mailin	g Address (Stree	et and Numbe	er or Rura	l Route Numbe	r, City or	Town, Sta	ate, Zip Code)
Gloria Jean Kant/	Sister	1	124	Dennis	Avenu	e,	Silver	Spri	ng, l	MD 20901
0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Damoval from State	20b. Place of cemete.	Dispos	sition (Name of natory or other p	ace)		Date 12,	20c. Lo	cation - C	City or Town, State
4 Donation 5 Other (Specify)				tan Crem			012,	Alex	kandr	cia, VA
21. Signature of Funeral Service License	e		Fr.	. Name and Add ancis J	ress of Facilit Coll	ins :	Funeral	Hom	e Ind	С
23a. Part 1. Inter the disease, or compl	continue that caused	he death Don							r Sp	ring, MD 20901 Approximate
shock, of heart failure. List only one	e cause on each line.	ne deam. Do i				oardido o	i roopii atory an	1001,		Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as a	consequence	dementia							unknown
	240 10 (0) 40 4	oo,,,ooquo,	5.65 57,							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	uence of):							
Cause (Disease or iinjury that initiated events	o		200							
resulting in death) Last	Due to (or as a	consequence of	nce orj.							
	d									
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal death		Ectopic pregna Other (specify)	ncy			:	23d. Date Mont	e of delivery th Day Year
Part II. Other significant conditions cor	ntributing to death bu	t not resultina i	n the u	nderlying cause	given in Part	I.	23e. Did to	obacco 11	se contrib	oute to the cause of death?
										3 ☐ Probably 4 X Unknown
Adul+ f	yten sic	w					24a. Was	an	24b. We	ere autopsy findings available ior to completion of cause of
17								ormed? 2 X No	de	eath?
5. Was case referred to medical examiner?	conital				Place of Dea	th (Check				
1 ☐ Yes 2 No H		nt 2 ER/Ou		t 3 🗆 DOA			me 5 Resid			
1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,		ime of njury		uryat ork? □Yes 2□	- 1	28d. Describe how injury occurred			1
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		rm, stre	eet, factory, office	9		28f. Location (S City or Tow			or Rural Route Number,
(Check 2 Medical Examin	cian: To the best of mer: On the basis of exa	amination and/o	r invest	igation, in my opi	nion, death or	ccurred at	the time, date a	and place,	and due t	to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NURUL (HONDHURY, MD; 605 Main St, Laurel, MD 2v7v7

31. Date filed (Month, Day, Year)

82. Registrar's Signature

D43121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0901 AM 2012 Medical 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4405 Oclan City Norceste Social Security Number If Under 1 Year If Under Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 24 Hrs. 8 Date of Birth Hours (Month, Day, Year) Director 219-16-1608 1 ፟፟፟፝ M 2 □ F 86 10-12-1925 Maryland ir than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Worcester Ocean City 1 X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14405 Tunnel Avenue, Apt. 111 21842 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 □ X Yes 2 □ No 1943—
If Yes, Give 1045 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Š 1 Never Married 2 A Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 1945 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 end 2 should be filed within 72 t Department of Health and Mentel Hygiene. Importent: If Item 27 is marked other than "na any Injury or other treumetic event state." 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Retail Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Webster King, Sr. Lillian Mae Elder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann King - Wife 14405 Tunnel Avenue, Apt. 111, Ocean City, MD 21842 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva10-13-2012 Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wante disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the deeth certificate be executed 24 hours after death. burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the ettending physician page 2 should be deteched for use es the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Waknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has t autopsy performed? Yes 2 N 2 (No 1 🗌 Yes To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မြ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 0-11-12 Name and address of person who completed cause of death (Item 23a) (Type, Print) Salish-00

DHMH 17 Rev 06-2011

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Ρ October 0 9:35 Kenneth Alvin King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Burnett Calvert Hospice House 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 212-48-2880 **Director** 1 💹 M 2 🗆 F 04-27-1946 66 Maryland Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Calvert <u>Huntingtown</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 6020 Huntingtown Road 20639 th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Retail Farm Supply Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alvin Thornton King Louise Beverly permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6020 Huntingtown Rd., Huntingtown, MD item 2 Nancy L. King, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Huntingtown UMC Cemetery 10/13/12 Huntingtown, MD ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility to e of Funeral Service License Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tre. List only one cause of each line. Part 1. Enter the d Approximate shock, or heart fail Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has page 2 autopsy perform or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural House 5 Pending work 1 🗌 Yes 2 No Investigation 6 Could not be Accident Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completely (Check 🔲 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) 10027189 MI 10.10.12 AF, 2417 Solomons Island Rd. Huntugtown, M

State Registrar

IDY

30. Name and address of pers

31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 18, 2012 ANNA ELIZABETH KENDALL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Chestertown Kent Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 220-01-8523 Director 92 1 🗆 M 2 🄀 F Aug. 19, 1920 10b. County 10c. City, Town or Location Director 28a-f MD Kent Chestertown 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? be by Funeral 300 Hadaway Drive Apt. 8A must 21620 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 💆 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: White If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Chemical Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien is marked other th 12 Shipping Clerk event, Be 17. Father's Name (First, Middle, Last) 2 Robert L. Usilton Florence Keyser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Lois K. Warrington Daughter 77 Clipper Way, Chestertown, MD 21620 other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Kent Cremation Services 10/19/12 10 I Department of Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State 4 Dopusion 5 Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Alzheimers Physician/ Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) tran that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Completed by Physician/Medical Box 68760 as the b 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) use 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN & Achol & Authoritis; 9/24 com 8 Records, has autopsy perform Yes 2 No Division of Vital funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Director: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State Smyrna, DE. Galena Funeral Home of Stephen L. Schaech Approximate nterval Between Onset and Death 3 years 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred work?
1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1.4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0050996 100Brown St. Clostertown MD 21620

2:35 a M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

MD

Registrar

filled in by the

Medical

1 🔀 Natural

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Accident Suicide

5 Pendina

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

ottoddavd MD

6 Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1635 Indian Valley Trail Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 215-22-0172 1 M 2X F 85 11/24/1926 MD Usual Residence of Decede show 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f MD 1 Yes 2 1 No Carroll Westminster 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1635 Indian Valley Trail 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 6 1 Never Married 2 X Married \$ 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Walter Joseph Hunt Nida Mary Elizabeth Brazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank W. Kowalski/husband 1635 Indian Valley Trail, Westminster, MD 21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. John Cemetery 10/23/2012 Westminster, MD 21. Signature of Funeral/Service Licensee 22. Name and Ad Pashet By Funeral Home and Chapel, PA all 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a consequence off The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent premant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant Pregnant at time of death 5 Other (specify) Month Day detached the 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sign Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy this certificate 1 Yes 2 No Yes 2 Hospital or Attending Physician: director. 25. Was case referred to redical æ 26. Place of Death (Check only one) examiner? 2 No ည 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t Certificate: 28b. Time of 28d. Describe how injury occurred Matural injury 5 Pending death, I Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after To the Hospital o within 24 hours aff To the Funeral Di completely filled in Medical 29a. Certifier 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

1

31. Date filed (Month, Day, Year)

NBV 0

29c. License numbe

12-07779 Timothy King

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 34948 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 14, 2012 **Medical Examiner** Timothy Ellise King 0238 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 1973 Aug. 19 October oreign Months Days Hours Director 220-94-8255 39 1 X M 2 F Country) Maryland Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Frederick Brunswick 1 X Yes 2 No Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
noti of Health and Mental Hygiene.
noti. If item 27 is marked other than "natural", or items 23a or 28a-f sho and: rother traumatic event, the Medical Examiner must be notified at ouce. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 209 West B Street 21716 United States of America uneral 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes 屲 White If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced Specify: **会** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 12 General Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Ellise King Ruby Brashears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Darr / Mother 209 West B Street, Brunswick, Maryland 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State October 18, 1 X Burial 2 Cremation 3 Removal from State Jefferson United Methodist Jefferson, Maryland 2012 Church Cemetery 4 Donation 5 Other Specify 21. Signature of Fure Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical aTramadol, Cyclobenzpine and ALcohol Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed 뗭 AMENDED 23a, pt. II, 27, 28a-f, per me, g933 11-5-12 sm 8 per fh g934 12-21-12 vt attending physician or use as the burial X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive Cardiovascular Disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? page ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural subject ingetsed drugs and alcohol 5 Pending 1 Yes 2 X No filled in by the fd 10-14-12 fd 1:40 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 X Suicide 6 Could not be or Town, State) 10662 Darcys Rd. Woodsboro, MD. (Specify) Single Family Home determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 14, 2012 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34949 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 5 Day 2012 Year Carolyn L. Ludwig 6:25 AΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 579-10-2311 96 yrs. Director 1 🗌 M 2 🔀 F Nov. 1, 1915 Washington, DC of Heelth and Mantal Hygiane. Item 27 is marked other then "netural", or items 23e or 28s-1 shov other traumetic event, the Medical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pege 1 end 2 should be fliv tment of Heelth end Mentel tant: If Item 27 is merked o Eugene Leach Carrie B. Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Mahaffey (Daughter) 13004 Brandon Way Road, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Depertment of H Important: If Ite any Injury or ot Date cemetery, crematory or other Matropolitan 1 🗆 Burial 2 🖾 Cremation 3 🖾 Removal from State October 10, 4 ☐ Donation 5 ☐ Other (Specify) 2012 <u>Alexandria, Virginia</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, (M00689)10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part J. Éfriter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or horst failure. List only one cause on each line. Approximate Interval Between Onset and Death infarction Immediate Cause (Final Physician/ MYOCALDIS disease or condition resulting in death) Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the deeth cartificate be executed within 24 hours after deeth.

To the Funeral Director: After this cartificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel these Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title 29d. Date signed (Month, Day, Year) D.20148 completed gause of death (Item 23a) (Type, Print) even 20110 MC

State Registrar 31. Date filed (Month, Day, Year)

Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ G. LeGrand 09705/2012 Albert а М 8:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 03/09/1934 Country) Days Hours Min. 577-46-5892 78 Director 1 2 M 2 D F N. or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at Director Prince Georges Fort Washington Md. 1X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #125 20744 6801 Bock Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1957 Black, White, etc. 2 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Company 12th Truck Driver Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth eny Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ల Albert Martin LeGrand Cassie Streeter 19a. Informant's Name/Relationship (Type, Print) (Nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip $_{
m Code}$) $2\,0\,7\,\overline{4\,4}$ Cedric LeGrand Jordan Ft. Washington, Ma 13106 Larkhall Circle Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cernetery, crematory or other place)
Cheltenham
Cheltenham 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/11/2012 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Latney's Funeral
3831 Georgia Ave., 21. Signature of Funeral Service Licensee 20011 Home NW Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: sician and e burlai-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burla Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) signed by the at I be detached fo 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been signated by page 2 should b 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 Yes 8 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှု 1 Npatient 2 ER/Outpatient 3 DO/ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print) 503 SURRATTS ROO . CLINTON MD 31. Date filed (Month, Day, Year)

State

Registrar

1 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Pauline В. Lewis 1:14 11, October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 006-03-0013 Director 1 🗆 M 2 🏻 F 92 May 16, 1920 Maine Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location Director 1 Yes 2 X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 USA 2208 Richland Place 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married Completed by Yes 2 No SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Midowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1
Department of Health and Menta
Important: If item 27 is marked
any injury or other traumatic ev 2 Deleen Bishop Joseph Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Richland Place, Silver Spring, MD 20910 Shannon M. Lewis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Oct. 13, 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service License 22. Name and Address of Facility.

Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd. W. Silver Spring. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Diverticular bleeding or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 X No g Unknown 9 Unknown cate has been signed by a page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Clostridium Difficile Infection 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has perform death? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🔀 No <u>_</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pendina Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Hospital within 24 hours of To the Funeral I Medical XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and tip 29c. License number October 12, 2012 D45471

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yeheyis Negussie, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No./ Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irving Robert Lane, Sr. 2012 October 10:00 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1710 Glenkarney Place Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Hours 577-16-2149 86 Director 1 🖾 M 2 🗆 F Yrs June 3, 1926 Washington, DC Usual Residence of Dece shov permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f showeny Injury or other traumatic event, the Machail Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location Director MD Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1710 Glenkarney Place 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 No <u>\$</u> 1 Never Married 2X Married Specify. White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Representative Retail Clerks Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lane Florence O'Toole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna R. Lane/Wife 1710 Glenkarney Place, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛱 Burial 2 🗌 Cremation 3 🗌 Removal from State Oct. 16, Gate of Heaven Cemeterly 4 Donation 5 Other (Specify) Silver Spring, MD . Signature of Funeral Service Licensee ²² Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition a Renal Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) within 24 hours after death.

To the Funer Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burieftransit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month 4 Pregnant g Unknown Pregnant at time of death ☐ Yes 2 ☐ No g [Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular Disease 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No I ☐ Yes 2 3N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) <u>م</u>| 1 ☐ Yes 2 😡 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D26287 October 11, 2012

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) 0CT 15 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Berard, MD 7305 Baltimore Avenue, #107, College Park, MD 20740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	larylan		artmer <i>tificat</i>			and M			/ 11 1 /	3495	3
				e (First, Middle, Las	t)			incar	01 2	Catif		2. Date of De			3. Time of Death	
	Physicia Medio			. Leonhard								October October	<u> </u>	012 Year	5:00 a.	M
	Examin	er		not institution, give	street and number)				Town, or ISTOWI	Location o	of Death			County of Dea	th	
5210	Funeral		7253 Winds 5. Social Security N		x 7. Aç	ge (In yrs. la	ast birthday)	If Unde	r 1 Year	If Under:	24 Hrs. Min.	8. Date of Bir	th	9. Bir	thplace (State or Forei	ign
	Director		578-26-2590 Usual Residence		⊐ м 2 Х F	95	Yrs.	Months	Days	Hours	IVIII1.	(Month, Da			untry) Oklahoma	
	and show dat	rot	10a. State	10b. County			y, Town or Lo	cation							10d. Inside City Limi	
	Mary 28a-f	irec	MD	Frederick		Adam	stown								1 X Yes 2 🗆	No
	s 23a or	Funeral Director	10e. Street and Nur 7253 Wind					10f. Zip	710				10g. Cit	izen of What Co U.S.	ountry?	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at the.		11. Marital Status 1	ied 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 K If Yes, Give Year or Dates.		l:	f Yes, spec	cify Cuba	spanic Orig n, Mexican Specify:	, Puerto	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.	
21215-0036	in 72 hou e. nan "natu Medical	Completed by	(Spe	15. Decedent's Ed cify only highest gra andary (0-12)		5+)	(Give I	ecedent's Usual Occupation Give kind of work done during most of working fe, DO NOT use retired)						16b. Kind of Business/Industry		
	d with lygien ther th	Be C			2.	,	Elect	ronic	Tech	nician				eral Gove	rnment	
lanc	be file ental H ked o	To E	17. Father's Name (Adam Boggs									e (First, Middle, Ussery	Maiden	Surname)		
Maryland	2 should Ith and M 27 is mar traumat		19a. Informant's Na	ame/Relationship (Ty)				-		and Numbe	er or Rura			Town, State, Zi	Code)	
Baltimore,	age 1 and ent of Hea nt: If item y or other		20a. Method of Disp	oosition Cremation 3	Removal from State	e Ci	lace of Dispo emetery, cren	sition (Nar	ne of other plac	e)	[Date	20c. Lo	ocation - City or		
altir	mit. Parame sortan sortan / injur.			5 Other (Specif)		Vega	7 Hi 17 (s of Facility	V	r 12, 20		Suitland,		
<u>m</u>	a In Deer		10	an 1	Y-//	14/1	2/1	/ 11 Pe	nnsv1	vania -				l Home, I 10 20746	nc.	
in.	Physician/		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition		lications that cause ne cause on each lin	ie.		er the mod	e of dying	g, such as	cardiac c	r respiratory ar	rest,	207 10	Approximate Interval Between Onset and Death	
and the same	Medical Examiner		resulting in death)		Due to (or as	a consequ	ience of):	ılmona	ry Eml	bolism						
	uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate rlying injury	Due to (or as Coronary	a consequ	ience of):									
	execuian an	al Ex	that initiated event resulting in death)		Due to (or as			TT	1	1						
68760	physic the b	edic		-	_{d.} Hyperten	sion,	Stroke,	нурот	nyroi	11511						
. Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. Funeral Directors. After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XXNo 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown							у			23d. Date of delivery Month Day Year			
s, P.O.	ires that the dea signed by the a Id be detached f	हि	Part II. Other signif	icant conditions co	ntributing to death	but not res	ulting in the u	ınderlying	cause giv	en in Part I	l.				the cause of death?	wn
Records,	The law require: sate has been się page 2 should b	Completed					*,					24a. Was auto perfo	psy ormed?	prior to death?	topsy findings availab completion of cause o	le of
E B	il cian: The certificate rector, paq	Be Cc	25. Was case refern	ed to medical			- 1		26. Pla	ace of Deat	th (Check	1 Yes	2 XX No	1 ☐ Ye	s 2 🗆 No	
of Vital	nysicia nis cer I direc	To B		WINO	Hospital: 1 ☐ Inpat	tient 2 🗆	ER/Outpatier	nt 3 🗆 D	Otho			1.0	dence 6	Other (Spec	ify)	
on of	inding Physic ath. r: After this one funeral dire	Certificate:	27. Manner of Deatl 1	5 Pending Investigation		ury ay, Yea <i>r)</i>	28b. Time of injury	M 2	28c. Injury work 1 🗀			28d. Describe I	now injury	y occurred		
Division	al or Attending F s after death. al Director. After t ed in by the funer.		3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inj building, et			eet, factor	y, office			28f. Location (3 City or Tov			ral Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in L	Medical	(Check 2			examination	and/or invest	tigation, in	my opinia	n, death oc	curred at	the time, date a	and place	, and due to the	cause(s) and manner st	ated.
	To the within 7 To the comple		29b. Signature and	stle of certifier sales from	on			290	DOO6					te signed (Mont ber 10, 2		
•	Sm			ess of person who c					JUS							
*	Cla		Vivian Dech	nosa, 610 So	Larex Court	rar's Sinnat	ure o	TIV ZI/								
	Stat Registra	ar	Ų.	Pay Year 2013	Census	1	ure fac	Find								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 1:00 a M <u>Elsie L. LaRue</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett Garrett Memorial Hospital Oakland If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 02-127-1932 Maryland 219-88-6512 **Director** 80 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Oakland MD Garrett Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1969 Foster Road 21550 12. Was Decedent Ever in U.S Armed Forceş? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 □ Divorced White Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Store Clerk</u> <u>News Stand</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. ဂ Helen Lavin Smith James Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1969 Foster Road Oakland, MD 21550 daughter Corinne Pappas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Emmanuel United Meth 10-20-2012 Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician vmon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate I funeral director, page Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15

State Registrar

Ù

Johnson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

am

,311,N 4th

Street Suite 2 Oakland MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rose Melillo Ledden October 0 ĬĞ. 2012 4:16Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14649 Barkdoll Road Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 150-18-6403 **Director** 1 🗆 M 2 💢 F 85 Dec. 21, 1926 New Jersey Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Hagerstown Washington 1 🗆 Yes 2 💢 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21742 14649 Barkdoll Rd. U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify.Whi te If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemakér Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other freeze 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Maria Rubetillo မ Angelo Melillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14649 Barkdoll Rd. Hagerstown, Md. 21742 (Son) <u>Kevin Ledden</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Smithsburg, Md. 4 Donation 5 Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service Licenser 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home M01414 AVIS Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physiciss/ disease or condition resulting in death) na Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Should . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has arthorte performe 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Mann of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred 1 Watural injury 5 Pending after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title D44996

Registrar

30. Name and address of person who

mpleted cause of death (Item 23a) (Type

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 12° 201² 4:30 Agatha Agnes Lantz Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Record Street Home Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days (Month, Day, Yea Director 217-18-7097 100 1 🗆 M 2 🕮 Maryländ Oct. 22,1911 Usual Residence of Dec permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115 Record Street 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 3 DWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leslie T. Alexander Edna Hutzell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Mountainview Place, Thurmont, MD 21788 Jett Pearce (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Boonsboro Cemetery 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 10/17/2012 Boonsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Footblook P.A. Funeral 16 E. Church St., Frederick, MO1612 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying signed by the attending physician and defected for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director. After this certificate has been six completely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Yes 2 140 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nursu Practition of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nursu Practition of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only une 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Casper Cline 300 W. 9th Street, Frederick, MD 21701

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18 am Lilly Bobbie tober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Viedic Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Months Hours Country) **Director** 235-62-8264 1 ₹ M 2 □ F 73 10/22/1938 West Virginia Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director or 28a-f MD Charles Waldorf 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 232 Barksdale Ave. 20602 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married N/, $(SODD)e^{-J/l}C^{+}$ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. White Specify. "natural", Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ Giant Food Shipper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Addie Harvey Ralph Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai once. 232 Barksdale Ave., Waldorf, MD 20602 Gwen M. Lilly/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Trinity Mem. Gds. 10/17/12 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Raymond Funeral Svc., 5635 Washington Ave., M01517 La Plata, 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Concer Physician/ disease or condition resulting in death) Medical as a consequence of): **Examiner** rseale Sequentially list conditions, Due to (or as a consequence f) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has page 2 autopsy performe death? 2 🗌 No Hospital or Attending Physician: funeral director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Expliminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and litle of 29d. Date signed (Mopth, Day, Year) 11 10 2012 person who completed cause of death (Item 23a) (Type, Print) stonld Scuto 203A 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 34958 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 1605 hrs October 8, 2012 Patrick Lavery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 116 Washington Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country) MD 1 X M 2 F 219-13-0712 25 4/22/1987 Usual Residence of Decedent 10a, State IOc. City, Town or Location 10d. Inside City Limits 1 Yes 2 No it. Pages I and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.

retant: If item 27 is marked other than "natural", or items 23a or 28a-f sho y or other traumatic event, the Medical Examiner must be notified at once. Elkton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 Washington Avenue 21921 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. 2 X No 1 Yes Specify: White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: **全** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 Fork Lift Operator Fork Lift 17. Father's Name (First, Middle, Last) i d. Mother's Name (First, Middle, Maiden Surname) Rayanne Thérèse Thompson Patrick Russell Lavery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Lavery Sr./father 116 Washington Ave. Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 10/13/12 Mark's Cemeter Perryville, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licen 22. Name and Address of Facil R.T. Foard Funeral Home, P.A. 259 E. Main St. Elkton, MD 2

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a Contact Gunshot wound of head Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a,27,28a-f,per me,g933 11-5-12 sm X UNPENDED signed by the attending physician be detached for use as the burial P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, has been a 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? r this certificate ha Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DOA 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural subject shot self Pending 1 Yes 2 X No fd 4:00 pm fd 10-8-12 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 116 Washington Ave. 3 X Suicide Could not be determined (Specify) Elkton, MD. found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 9, 2012 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CAROLE Μ. MARUSCSAK 2012 0500 A M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Deatl 4c. County of Death YENINSULA REGIONAL MEDICAL SALISBU HICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **Director** 121-34-8847 1 □ M 2 🔀 F 70 12-22-1941 York New Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director De3awar¢ Sussex Seaford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8498 Gum Branch Rd 19973 US filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Owner 12 other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental H 27 is marked of traumatic ever þ August Seidenfeden Murial Boardwick permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8498 Gum Branch Rd, Seaford, DE 19973 Julius Maruscsak - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory 10/15/201 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ²² Name and Address of Facility
Cranston Funeral Home Cranston P O Box 967 Seaford. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ sa resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The raw requires what we wish the after death.

Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician: completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No Pregnant at time of death Day 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 ☐ Yes 2 ☑ No BB B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 24 No ည 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) led (Month, Day, Year) State 32 15 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Roknick Medich 10:55 AM Medical October 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Denton Caroline Nursing Home . Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of billion (Month, Day, Y 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Pennsylvania 209-16-7596 Director Sept Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Caroline Denton 1 XYes 2 No 10e, Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ě Funeral an "natural", or items 23a Medical Examiner must b 21629 United States 520 Kerr Avenue 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home ulth and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter Roknick Ljubica Skrbina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28652 Clubhouse Drive, Easton, MD 21601 item 27 Nadine M. Hilghman/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 cemetery, crematory or other place, permit, Page Department of Important: If any injury or once. Delmont, Pennsylvania Twin Valley Memorial Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Framptom Funeral Home, P.A. <u>216 N.</u> Main St. Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, Medical resulting in death) Due to (or all a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi and Due to (or as a consequence of) resulting in death) Last attending physiclan for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months' 1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown the detached 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate performed 2 🗌 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ n 24 hours after death.

• Funeral Director: After this objected filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within To the only one)

State Registrar 29b. Signature and title of certifie

30. Name and address of person wb

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completed cause of

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NELVA MEDFORD 3:40A M Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22380 Hog Creek Road Caroline Preston Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) Hours Director 283-20-4783 1 □ M 2 🔽 F Yrs. 86 Sept. 9, 1926 Ohio "natural", or items 23a or 28a-f shov edical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Caroline 1 Yes 2 No Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22380 Hog Creek Road 21655 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 2 X No 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Nichols Lucy Ruppert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Lester Medford 22380 Hog Creek Road, Preston, MD 21655 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/20/12 Urbana, Ohio 4 Donation 5 Other (Specify) Kingscreek Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Alzheimer Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops Coronary Artery After this certificate s after deau... ral Director: After this ceru... 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔼 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours a

To the Funeral C

completely filled hours a Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 00532 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston Sniezek 21655 CHOPTANK MD MD 32. Registrar's Sign State Registrar

DHMH 17 Rev 06-2011 AS3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No./ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24, 2012 Physician/ 7:39 Ρ Kenneth Christopher McCracken Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Capital Heights 6901 Drylog Street Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 579-94-5189 1 🛛 M 2 🗆 F Yrs Jan. 11, 1967 Maryland 45 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Capital Heights Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 0 ms 23a or must be r Funeral United States 20743 6901 Drylog Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) i "natural", or item edical Examiner n 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes. Give Specify: 3 Widowed 4 Divorced Black Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Emergency Operation
Information Special (Specify only highest grade completed) r than " the Mr Operations & on Specialist Elementary/Secondary (0-12) College 71-4 or 5+) filed within tal Hygiene. Government other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked otl LeRoy McCracken Eugartha Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6901 Drylog Street Capital Heights, Maryland Monica E. White-McCracken /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State rtment of F. 10/23/2012 Beltsville, MD 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any njury or once. Chesapeake Crem. wak. 4 Donation 5 Other (Specify) unk unk. 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service Licenses Inc. Stemant 20019 4001 Benning Road NE Washington, DC M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hypertension disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Obesity BMI 67 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): death certificate be executed as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 inding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months? ò Day Month Year Other (specify) Pregnant at time of death 5 2 No ed by the a 1 Yes 2 L 9 Unknown g Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. 2 🗌 No 3 🗌 Probably 4 🟝 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an ate has I page 2 s autopsy performed' death? Yes 2 X No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at work? After iniurv 1 X Natural 5 \square Pending 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2.

To the F

complet only one 29d. Date signed (Month, Day, Year) and title of cer Signat October 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

Nicole Richardson, MD

32. Registrar's Signature

700 2nd Street NE Washington, DC

20002

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
PI LINE B, 25, PER ME G933 11/29/12 TRT
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 9 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Joseph Martin 7:35 A M 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 815 Sheridan St. Hyattsville Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Ward, SC Days Hours (Month, Day, Year) 5/14/1914 Director 202-22-5950 1 M 2 □ F 98 Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then "netural", or Items 23a or 28e-f show any Injury or other treumatic event, the Modical Examiner matter to motify at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Hyattsville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 815 Sheridan St. 20783 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 **Black** 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 🕅 No Specify: ir res, Give Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Army Sergent 1st Class 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Gov't 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Tillman Benjamin Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mattie Morgan/ Companion 1011 Hamilton St. NE Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🂢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ArTTitgton Nathonal Arlington, VA 22. Name and Address of Facility Johnson & 21. Signatur - Funeral Service Licensee Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Chronic Hirway disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The lew requires that the death certificate be executed After this certificate has been signed by the ettending physicien end infuneral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performe death? Yes 2 No 2 🗆 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month) a se of death (Item 23a) (Type, Print) McCornick 31. Date filed (Month, Day, Year) State 6 Registrar

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			For State	State of M	aryland /	•			Mental Hy	giene	10	34964
			Registrar			Certificat	e of De	eatn	Ta a	Reg. No.		0.10
	Physicia Medic			ANWAR	MAC			Ε.	2. Date of De	RIP, 2	Year	7,53 M
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	Funeral Director		5. Social Security Number 6.	Sex 7. Ag 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e (In yrs. last bi	irthday) If Under Months Yrs.		Hours Min		ay, Year)	9. Birthplac Country)	e (State or Foreign
	and show	ō	Usual Residence of Decedent 10a. State 10b. County			wn or Location			7000	///3	10d.	Inside City Limits
	e Maryla r 28a-f notifiec	Director	DELAWARE K	ENT	De	OVER	p Code			10g. Citizen of	M/L at County	1 Yes 2 □ No
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral I	104 CANDLEWIG	CKE DRIV	E		1990	/		U.S		·
980	s after death ral", or item Examiner n	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent S Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	p*	If Yes, spe	cify Cuban	panic Origin? (§ , Mexican, Pue Specify: A			ce - American lock, White, etc.	
M/W/	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myn hiury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			ia. Decedent's Usu (Give kind of wo life. DO NOT us PH	ork done du	ring most of wo	orking	16b. Kind of B		•
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Mary	12 should alth and I		19a. Informant's Name/Relationship REHANA MALFK	(Type, Print) / WIFE	19	8189 E	•		tural Route Numbe			e) 2/043
$^{\prime}$ /more,	age 1 and ent of Hea ht: If item y or othe		20a. Method of Disposition 1 ABurial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place cemei	of Disposition (Na tery, crematory or	me of other place	10	Date 13/12	20c. Location		State RYLAND
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	Pnysician/ Medical Examiner		disease or condition resulting in death)	a. Que to (or os	a consequence	e of):	· Cac				_	
y	d sii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	e of):						
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal dea	ath 3 ☐ Ectopic n 5 ☐ Other(s		,			ate of delivery onth Da	ay Year
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Rec	: The la icate ha r, page	Com							perl 1 🗆 Yes	formed?	death? 1 ☐ Yes 2	
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Division of Vital Records,	or Attend after death Director: A	Medical Certificate:	3 Suicide 6 Could no	2 Accident Investigation 3 Suicide 6 Could not be							er or Rural Ro	oute Number,
۵	Hospital 24 hours Funeral etely filled	ledical	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of urse Practitioner: To the	examination and	d/or investigation, in	my opinior	n, death occurre	d at the time, date	and place, and du	ue to the cause	(s) and manner stated.
	To the vithin To the comple	Σ	29b. Signature and title of certifier	ALGO FRACTIONET: 10 T	io beat of filly Kr		c. License		\sim	29d. Date signe	ed (Month, Day	, Year)
	6		30. Name and address of person wh	o completed cause of o	death (Item 23a	a) (Type, Print)	100	1060		Wood,	12-	1
92	(J9 ⁴ Sta	te.	31. Date filed (Month, Day, Year)	1400 M.	rar's Signature	1601 0) S Lex	2 DKi	ve w	WSUN,	MARY	NANC 1
	Registr		OCT 1 62012 A	was .	park						0	404

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

29b. Signature and title of certifier

Donna M. Vincentí, MD

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 12, 2012

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

92012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MARIE MINGO 10 - 11:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6513 LACONA STREET DISTRICT HEIGHTS 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** Hours **Director** 579-34-2941 1 □ M 2X□ F 83 4-7-1929 DC Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director X 1 Yes 2 No MD PG DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 6513 LACONA STREET 20747 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify:BLACK 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT 12TH and Mental Hygien is marked other the CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important: If item 27 is marked any injury or other transpine. 2 HERBERT SLAUGHTER MYRTLE FLOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA ROBINSON/DAUGHTER 6610 LACONA STREET DISTRICT HEIGHTS, MD 20747 Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other r LINCOLN MEMORIAL 1 X Burial 2 Cremation 3 Removal from State 10-12-2012 SUITLAND, MD 4 Donation 5 Other (Spegify) 22. Name and Address of Facility POPE FUNERAL HOMES, re of Funeral Service 10 5538 MARLBORO PIKE, FORESTVILLE, Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has performed? Yes 2 No death? 1 ☐ Yes 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred s after death. I Director: After the injury 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined within 24 hours a

To the Funeral E

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Territying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 1+0067560 5M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

THUY HOANG, M.D.

UCI 1 2 2012

31. Date filed (Month, Day, Year)

BRANCH

6104

AVE, TEMPLE HILLS, MD 20748

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State	partment of Health and Me		2012	34967
		Registrar 1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death	No. <u>2</u> U <u>2</u>	3. Time of Death
Physic Med		Louise D. McGhee	o	ctober .	7 2012	6:30 A™
Exami	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funera	7	17813 Covent Garden Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth	Montgomery 9. Birtho	ace (State or Foreign
Directo		246-38-1220 1 □ M 2 🖾 F 84 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Count	(Y)
and show at	ا ة	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		april 29,	1928 North	Od. Inside City Limits
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flaryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 9 Barn Ridge Court	10f. Zip Code 20906	10g.	Citizen of What Count	ry?
eath w tems ?	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specif	fy Yes or No-	14. Race - America	in Indian.
36 after d	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 1 ☐ Yes Give	If Yes, specify Cuban, Mexican, Puerto Ri 1 Yes 2 X No Specify:	can, etc.)	Black, White, e	tc.
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Editimore, permit. Page 1 and Department of Hea Important: if item any injury or other once.			2. Name and Address of Facility Fort			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	401 Bladensburg Rd	Brentwoo	od, Md 207	
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Physician: 1 Physician: 1 r this certifica	Be	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	eet, factory, office 281	f. Location (Street a City or Town, Sta	and Number or Rural F	oute Number,
spital hours a neral II		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	due to the cause(s)	and manner as stated	
the Ho nin 24 I the Fu npletel	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred at the	e time date and pla	ice and due to the caus	e(c) and manner stated
vitl To		29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Da	ıy, Year)
SIM		30. Name and address of person who completed cause of death (Item 23a) (Type,	D 0061645	/	0/9/12	
		May Ellen Ritchie MD 29	OI Olney Sandy Sx	oring R	d Olney	WD 20032
Sta Registr		31. Date filed (Monty), Day, Year) 32. Registrar's Signature	DOOG 16 45 Oi Olney Sandy Sy)	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2016 of Reary Etho 6933 partition of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month / 0340 M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Nursing & Rehabilitation Ctr Clinton Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min Director 1 🖾 M 2 🗆 F 240-88-0869 1951 Usual Residence of Decedent North Carolina items 23a or 28a-f show ier must be notified at 10a, State 10h County 10c. City, Town or Location Director Clinton 1 X Yes 2 No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20735 United States 9211 Stuart Lane within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. "natural", or iter Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Maintence Private Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert McBride Arrie Lois Broadway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Porter - Sister 3015 Kirtland Avenue Forestville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Clinton, Maryland unk. Lee's Crematory unk. 10/16/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee M00560 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the property to the property of the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of per se of deat 100 Registrar's Sig. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $1\overset{\text{Day}}{1}$ 2012 October 0 10:36 Sheila Irene Martin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6212 Mallard Lane Lothian Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral Director** 578-52-5277 1 □ M 2 🏋 F Wash., D.C. 02-15-1941 Usual Residence of Dec 3a or 28a-f show t be notified at 10b. Count 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No MD Anne Arundel Lothian 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral ould be filed within 72 hours after death with to Mental Hygiene.

marked other than "natural", or items 23a USA 6212 Mallard Lane 20711 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar leted 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 accountant oil company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be 1... 2 Isabelle Meddings Carlton Cecil King, Sr. and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s t of Health If item 27 i or other tra 6212 Mallard Lane, Lothian, MDCheryl L. Dwyer, Daughter 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 0 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 X Other (Specify) Entembrent Memorial Gardens 10-16-2012 Dunkirk, MD 22. Name and Address of Facility LFuneral Service Licenses Rausch Funeral Home, P.A. M00715 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and -trar that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown been sig Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas page 2: autopsy perform death? certificate □ Yes 2 No __ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check $_{3}$ \square **Certifying Nurse Practitioner:** To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signatu 29d. Date signed (Month, Day, Year) 2012

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

OCT 12

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ANNAPOUS MD 2140

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		-	State o State Amend #5, 10-18-2012	f Marylan 2, per F	d / Depa HDR _{Ce} J	rtment of H	ealth and N <i>eath</i>		giene Reg. No.2 ()	12	31,970	
			Hegistrar Decedent's Name (First, Middle, Last)	, ,	001	ancare of B	- Catir	2. Date of De	ath	1.6	3. Time of Death	
н	Physicia Medic		Dorothy J. McGuinn					october	· 14 20	12 12	10:30 a M	
and of	Examin		4a. Facility Name (if not institution, give street and num	•		4b. City, Town, or			4c. County of			
, and			3010 N. Ridge Road C4 5. Spring Becoming Numbers 6. Sex	15 7. Age (In yrs. la	ot hirthday	Ellic	cott City If Under 24 Hrs.	8. Date of Birt		ward	ace (State or Foreign	
	Funeral Director		5. So 6. Sex 102-18-9946 1 M 2 25 F	7. Age (III y/s. la	Yrs.	Months Days	Hours Min.	(Month, Da	ry)			
	MC .		Usual Residence of Decedent					09/22/1	.927	NY		
	rylanc -f sho ied at	Director	10a. State 10b. County MD Howard		, Town or Loc					10	0d. Inside City Limits 1 Yes 2 No	
	or 28a	Dire	MD Howard 10e. Street and Number		ETTTCO	tt City			10g. Citizen of W	hat Count		
	with the 23a cast be	Funeral	3010 N. Ridge Road C4	15		2	21043		Unite			
	items		11 Marital Status 12. Was Dece	dent Ever in U.S	5. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spenic Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America		
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	d by	Armed For 1 Never Married 2 Married 1 Yes, Giv	9		Yes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:		White	
21215-0036	nours natura ical E	etec	15. Decedent's Education	tes.		ent's Usual Occupa			16b. Kind of Bu			
215	in 72 le. e. nan "r Med											
21	iled within I Hygiene. other thai	(a)	2		Subst	itute Tea			Element		3chool	
and	フラチままり											
17. Father's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Middle, Middle, Middl										ode)		
	d 2 shalth a		John P. McGuinn, III -	son	457	Red Cedar	Road L	ake Vil	la, Illi	nois	60046	
Baltimore,	ge 1 and of Healing 1: If item 2		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from		lace of Dispo emetery, cren	sition (Name of natory or other place	e)	Date	20c. Location -	City or Tov	vn, State	
ţ	t. Pag tment rtant: ijury c		4 ☐ Donation 5 ☐ Other (Specify)			wn Mem.		/2012			ille, MD	
Bal	permit. Page 'Department o' Important: If any injury or once.		21. Sign fur of Funeral Service Disensee		41	12 Old Co	olumbia P	ike Ell	icott Ci		ly FH Inc. MD 21043	
			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ea	ch line					rest,		Approximate Interval Between	
- Care	Medical		Immediate Cause (Final disease or condition resulting in death)			17.c]	JI Sea	4			Onset and Death	
A SAME	Examiner		Due to (or as a consequ	ience ot):							
	4.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ರ್ಯ ಪತ್ರ ಪ್ರದೇಶಕ್ಕಳು	lende oi).							
	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events c.									
	ate be executed physician and s the burial-transit	ial E	resulting in death) Last Due to (or as a consequ	ence ory:							
760	physics the	edical	d									
Box 687	death certificate be ne attending physici ed for use as the bu	N/N	23b. Was decedent pregnant	come of pregnal		Ectopic pregnancy	1		23d. Date	e of delive	ry	
B 0)	requires that the death certifica been signed by the attending p should be detached for use as	Physician/M		nant at time of c		Other (specify)	<u>'</u>		Mor	nth	Day Year	
P.O.	at the	/ Ph	Part II. Other significant conditions contributing to d	eath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contri	bute to the	e cause of death?	
S, F	The law requires that the ate has been signed by the page 2 should be detach	ed by						1 🗆	Yes 2 No	3 🗌 Prob	ably 4 🗆 Unknown	
ord	w requ	Completed						24a. Was	-		sy findings available	
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tal	cian: ertific ector,	Be	25. Was case referred to medical examiner?			26. Pla	ice of Death (Chec	k only one)				
Ϋ́	Physi r this c eral dir	<u>ان</u>	1 Yes 2 No 1 Description 1 28a. Date	Inpatient 2 of injury	ER/Outpatier 28b. Time of	t 3 DOA Ottle	4 ☐ Nursing He		dence 6 Othe			
o uc	nding ath. r: After	icate	1 Natural 5 Pending (Moni 2 Accident Investigation	h, Day, Year)	injury	work'			ion injury occurre			
Division of Vital Records,	l or Atte after dea Directol d in by th	27. Manner of Death 1 Actional 5 Pending 2 Accident 1 Newstigation 3 Suicide 4 Homicide Homicide Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 28d										
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3										
	To the within To the comple	Σ	only one) 3 L Certifying Nu/se Practitioner 29b. Signature and title of pertifier	TO THE DEST OF IT	ny knowledge,	29c. License		ace, and due to	29d. Date signed			
) mn			D4.	(440		Octob	n 1	5,2012	
	8		30. Name and address of person who completed cause	e of death (Item	23a) (Type, F	crint) Larry	Colu	mbs'4	Mag	161	ndi	
	State Registra		31. Date filed (Month, Day, Year) 0CT 1 6 2012 32.	egistrar's Signat	D. A	arkel				,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10. Month October 2012 8:55 P M Alexander Peter Murray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Hospice Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Director 189-46-3412 1 ■ M 2 □ F Yrs. July 10,1956 56 England Usual Residence of Deceder ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland 1 Yes 2 No Gaithersburg Maryland Montgomery ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20882 24305 Clematis Drive United States within 72 hours after death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Chemical Federal Govt. 6 Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be.
Department of Health and Mental.
Important: If item 27 is morany injury or other? ပ္ Mrs. Frances J. Glaisher Mr. Peter Murray 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gloria A. Oliverio-Murray, 24305 Clematis Drive, Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery Oct. 15, 2012 Germantown, Maryland 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
20401 Ridge Road, Damascus, Maryland 20872 21. Signature of Funeral Service M01393 23a. Part Part A Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Pnysician/ Metastatic Rectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to hours after death. Funeral Director: After this certificate has been signed by the attending physicial. Division of Vital Records, P.O. Box 68760 IF FFMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ulcerative Colitis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the I within 2

State Registrar only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Bindu, Montgomery Hospice, 1355 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year)

32. Registrar's Signature

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0060634

29d. Date signed (Month, Day, Year)

October 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Willie Adelaide October 2012 5:57 Murphy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 636 Wilson Place Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Director 219-12-1556 1 🗆 M 2 🕱 F Feb. 18, 1925 87 Maryland Usual Residence of Decedent at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f st be notified Frederick 1 X Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 21702 636 Wilson Place United States items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō Completed by 1 Never Married 2 Married 2 🔀 No 1 Yes 2 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White "natural", Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 11 Sales Associate Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ William Edgar Shaff Stella Mae Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Frederick, Maryland 21702 Sharon Murphy / Daughter 636 Wilson Place 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important; If ite any Injury or ot 20c. Location - City or Town, State October 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 12, 2012 St. Luke's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Feagaville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the dileave, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Ogset and Death Immediate Cause (Final Physician/ oncestive neart disease or condition resulting in death) Medical Due to (or as a connequence of): **Examiner** Due to for as a consequence of). Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ~ 220nora burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? atrial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? Yes 2 certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Boute Number. after determined City or Town, State hours Funeral Medical 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) depoilm) ND 020860 2012 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Brunswick MO 21716

Gessert, mo

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Cert	tificate o	f Death			Reg	g. No.		
Physici		Decedent's Name (First, Middle Control of the	(First, Middle, Last) 2. Date of Death Month Day Year									me of Death
ledical Exami	iner	Steven Lee Mar	tin						October 17	, 2012	17	756 hrs
		4a. Facility Name (if not institution	- · -	er)		4b. City, Town,		of Death		4c. County of		
		Baltimore Washingtor				Glen Buri				Anne Aru		
Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. la	st birthday)	If Under 1 Y	fear If Under		3. Date of Birth	n(MM/DD/YYYY)	9. Birthplace Foreign	e (State or
Director		216-92-0281	1 ∑∑ M 2☐F	38	Yrs		ays nours	10/22/1973			Country)	VA
		Usual Residence of Decedent										
v any		10a. State 10b. County		10c. City,	Town or Locat	tion						Inside City Limits
ryland ia-f show	ō	MD Anne	Arundel				Pasad	dena			1 _	Yes XX No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Zip Code	Э		100	g. Citizen of Wha	at Country?	
the N	Dir	8150 Elizabeth	ı Rd.			1	21122				USA	
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hould hould Me is ma	မ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									, State, Zip C	Code)
7 7 9 7 4 1		Amanda Martin Former Spouse 765 Seneca Dr. Odenton, MD 2										
Ore, Nges I and Gof Health	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. L								20c. Location - 0	Dity or Town,	State	
Baltimore, Mi permit. Pages 1 and 2 s Department of Health a Important: If item 27		1 Burial 2XX Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Atlantic Crematory 10/19/2012 Glen Bi								urnie,	. MD	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Juicido Jui	d not be (Specify)	Resid	lence				or Town, Sta asadena	te) 8150 E	lizabe	th Rd.
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To the Hos within 24 h To the Fun completely	Medical	(miner:On the basis of ex	amination and								e(s)
To with	Š	29b. Signature and title of certifie	and manner stated	1.		29c. Lice	ense number			29d. Date signed	(Month, Da	ay, Year)
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		30. Name and address of person		doub (box (220)							
			nt Medical Examine			re Street. B	altimore. N	ИD 2122:	3			
St	ate	31. Date filed (Month, Day, Year)		1 61 1								
Regist		OCT 23	3 2012 Den	wa.	B. A.	ark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eileen D. Millan Physician/ 2012 October 7:13 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis 71 S. Winchester Road Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days Hours Year 212-42-7212 108 Director Aug. 20, 1904 1 ☐ M 2XX Canada permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any pines. 10b. Count 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location Director Maryland Anne Arundel Annapolis 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 71 S. Winchester Road 21409 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medicine Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jeanne Gaudet Edward Patrick Doherty 19a. Informant's Name/Relationship (Type, Print)
Sherri Millan/granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 151 Arnold, Maryland 21012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State 10/10/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ evelor veru one disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conse and ce of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atter page 2 should be detached for Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ❷ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home <u></u>은 this (Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 2 Accident 5 Pending injury 1 Yes 2 No after death. Investigation Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Gilen Burnie S. Crain St. 106 600 WP T1 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death Physician/ October 15, 2012 10:05 P.M Henrietta Shirley McFerren Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death
Washington Examiner Smithsburg 11541 Pleasant Valley Rd. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 186-28-2807 Director 1 □ M 2**X**□ F Nov. 17, 1934 Maryland or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo Smi thsburg Md. Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö "natural", or items 23a o Funeral U.S.A 21783 11541 Pleasant Valley Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1

Yes 2

No
If Yes, Give
Year or Dates. Black, White, etc ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed er than "natur the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Monce. Restaurant Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Page 1 and 2 should be innent of Health and Ments Edna Mae Bowman James R. Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Moody Rd. Standish, ME. 04084 Robert M. McFerren (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Pleasant Valley United Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) Methodist Church dr Cem Pacility Signature of Funeral Service Licenses 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg.Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Out and Death Immediate Cause (Final Physician/ ranoma Lyear disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Securitally list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 Yes 2 1 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: After 1 1 Matural 5 Pending iours after death.

neral Director: At filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical To the Hospi within 24 hou To the Funer completely fil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2012 son who completed cause of death (Item 23a) (Type, Print) Avenue Hagerstown MD Thetn 31. Date file 32. Registrar's S Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day O6 Northam. Thomas EDWARD 8:00 P M 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CAMBRIDG E DORCHESTER BAY MALLARD NURSING HOME Social Security Number 8. Date of Birth (Month, Day, Yea Mar. 20, If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Country) Maryland 214-52-0870 Director 1 XM 2 □ F 64 1948 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Hurlock Dorchester MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 204 Hurlock Avenue United States 21643 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ۾ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Freight Truck Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot Willie Preston Northam Iona Belle Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mardela Springs, MD 21837 Edward T. Northam, Jr./Son 9368 Bel Air Drive, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or c 1 Burial 2 Cremation 3 Removal from State Fastern Sh. Veterans Cem. 10/11/12 Hurlock, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Frampton Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CIRR HOSIS disease or condition resulting in death) OF THE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24 hours after death. § Funeral Director: After this certificate has been sig-lietely filled in by the funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 69234 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET CAMBRIDE ERRABOLV 21613 I EE VAN 503 BYRN

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clarisse Niyonkuru 2012 1:55 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Park Takoma Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 579-29-5977 Director 49 1 □ M 2 🗆 KF 12/25/1962 Burundi Usual Residence of Deced i Hyglane. other than "netural", or items 23e or 28e-f show vent, the Medicel Examiner. Het be notified at within 72 hours after daath with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Md. Prince Georges Takoma Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral New 6731 Hampshire Ave.#613 20192 Burundi 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ፩ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home Certified Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fia marked o pa Ngen Dakumana parmit. Page 1 and 2 should ba Dapertment of Haelth and Meni Important: if Item 27 ia marke any injury or other treumetic. Hadija Mukaraguzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Jackson/ husband New Hampshire Ave.#613 Takoma Pk. Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 10/12/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood. Md. 21. Signature of Funeral Se 22. Name and Address of Facility Universal Mortuary 411 Kennedy St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner mmhnodofi Liency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to forks a consequence of Exami To the Hospital or Attending Physician: Tha law raquiras that the daath cartificate ba axacuted within 24 hours aftar death.

To the Funeral Director: Aftar this certificata has been signed by tha attending physician and completaly filled in by the funeral director, paga 2 should ba datachad for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 W Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Julyath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Petural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 0-0572 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alomina 14 Sough 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 15 Daniel Thomas Nee 201² 3:15 Ρм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death 7030 Arbor Drive Frederick Frederick 5. Social Security Numbe 217–12–1516 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Hours May 28, 1924 88 **Director** 1 XM 2 □ F J. Hygiene. Jother than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at. 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7030 Arbor Drive 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 ☐ No 1 [Oses] Guite 9 (46) Year of Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3X Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Quality Control Manufacturing other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Francis Nee Ethel Mae Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susanne Basford (Daughter) 604 Huntover Lane, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cem. 10/20/2012 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signardre of Funeral Service Licensee 22. Name and Address of Facility Seeney & Basford 106 E. Church St P.A. Funeral Home ., Frederick, MD 21701 186 MO1612 23a. Part 1 Inter the disease, or symplications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Date to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month 1 Yes 2 9 Unknown the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by I completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 $\stackrel{\bullet}{X}$ Residence 6 $\stackrel{\frown}{\square}$ Other (Specify) 욛 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Math 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and ox investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/ox investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Dr. Robert Kaufmann, 300 W. 9th Street, Frederick, Maryland 21701 32. Registrar's Signatu State

Registrar

			For State	se Type or State			d / Depa		t of H	lealth	and N	II Copies Mental Hy		е	e.	21.07
	Physicia		Registrar 1. Decedent's Name (First, Middle James Arch						0 0			2. Date of D Month Oct 9,	eath D		ear	3. Time of Death 11:20 A M
	/Medic Examin		4a. Facility Name (If not institution 210 Buckler Road	n, give street and n	umber)			Hunt	ingto					c. County of I		
	Funeral Director		5. Social Security Number 219–28–8489	6. Sex 1		e (In yrs. la 81	ast birthday) Yrs.	If Unde Months		If Unde Hours	r 24 Hrs. Min.	8. Date of B (Month, D Sept 1,	irth Day, Year 1931	9. V:	Birthpla Countr irgin	ice (State or Foreign y) 1a
	th the Maryland or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Calver 10e. Street and Number				y, Town or Lo	/N 10f. Zi _j						10d. Inside City Limits 1 ☐ Yes 2☐ No Citizen of What Country?		
	2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. Is marked oither than "natural", or Items 23a or 28a-f show laumatic event, I'm Medical Evan Inc. oust be notilied at raumatic event,	by Funeral Director	210 Buckler Road 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was De Armed F ried 1 💆 Yes	orces?					lispanic O an, Mexica Specify		pecify Yes or No Rican, etc.)		Black, V	Race - American Indian, Black, White, etc.	
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ומוות ד	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other than any Injury or other traumatic event, Ir. M. ODE.	To Be Co	17. Father's Name (First, Middle, Laymon Lee O'De								her's Nam	e (First, Middl	le, Maide	en Surname)		
, IVIG. y	1 and 2 shou Health and N em 27 Is mar ether traumat		19a. Informant's Name/Relations Rubylee 0*Dell -				210 B	ickler	Rd. I	Huntir	ngtown	ral Route Num MD 2063	9			
	t. Pages 1 tment of Hi tant: If iten		20a. Method of Disposition 1 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Highlands Memorial Gardens 20c. Location - City or Town, State Chesapeake Highlands Memorial Gardens 20c. Location - City or Town, State Port Republic Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home													
3	permit Depar Impor any In		21. Signature of Funeral Service	ch			44	105 Br	oomes	Is. F	Rd. Po	rt Repub	lic,			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on $\frac{m_{3}}{m_{3}}$	each lir	ie.	neo					or respiratory				Approximate Interval Between Onset and Death
	executed an and rial-transit	lical Examiner														
	at the death certificate be by the attending physici tached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e birth gnant a	of pregna 2 ☐Fetal t time of d	I death 3	⊒Ectopic ⊒Other (s		СУ				23d. Date of Month		y Day Year
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11000	Physiclan: The law requin rthis certificate has been si ral director, page 2 should I	Completed										pei	is an lopsy formed?	prio dea		sy findings available opletion of cause of
2	siclan: The certificate I rector, page	Be	25. Was case referred to medica examiner?	Hospital:					OA Oth	ner:		th (Check onl)				
5	ding Phy: h. After this funeral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Dat	<u> </u>	ry	28b. Time o		28c. Inju	ry at	Nursing H	ome 5 Re 28d. Describ			(Specify)
	To the Hospital or AttendIn, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	145 Natural 5 ☐ Pendir 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	gation not be 28e. Place	ce of Inj		Injury ome, farm, sti y)	M reet, factor		Yes 2[□No	28f. Location City or T	(Street own, Sta	and Number ate)	or Rural	Route Number,
	the Hospit hin 24 hours the Funera	Medical (ng Physician: To t Examiner: On the and ma		f examina		vestigatio	n, in my	opinion, d	eath occu		e, date a	and place, and	d due to	the cause(s)
1		M	29b. Signature and title of certific	200					c. Licens	numbe	24		29d. l	Date signed (Month, E	Pay, Year)
P	w 6+1		30. Name and address of person	de MD	2.	38	Mer	Print)	c Cf	R	rinu	Fre	d,	MO		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 09 Robert Michael Ochall 2012 13:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Director 161-26-5119 78 1 XM 2 □ F 02/22/1934 Pennsylvania Usual Residence of Decedent shov 10a, State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Davidsonville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Appomattox Road 21035 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black. White, etc. <u>۾</u> 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🕅 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 H.V.A.C. Specialist D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Department of Health and Ment, Important: If item 27 is marked any lujuy or other transpore. Michael Ochall Mary Michaylo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
704 Appomattox Road, Davidsonville, Maryland 21035 Alberta M. Ochall/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/15/2012 Davidsonville, Maryland 4 ☐ Donation 8 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility George P. Kalas Funeral Home ervice Lic 2973 Solomons Island Road, Edgewater, MD 21037 part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ rebravas disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mia Sequentially list conditions. if any leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus Hypertensi 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Pinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

2001

11 2012

31. Date filed (Month, Day, Year)

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #26 Per FH JM 10/Gertificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:18AM Physician/ MERLE MARIE Month 10 Medical Facility Name (if not institution, give street and number)
Bowie Medical Center 4c. County of Death Prince George's 4b. City, Town, or Location of Death Bowie **Examiner** 9. Birthplace (State or Foreign Country) _ VA . Social Security Number 577-46-1978 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Days Hours 1 🗆 M 2 🖰 F **Director** 75 Feb.8, 1937 Front Royal ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Prince George Lanham 1 X Yes 2 ☐ No 10e. Street and Number 6512 Westview Lane 10g. Citizen of What Country? 20706 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) Collage (1-4 or 5+) Payroll Supervisor Fed. Govt. (OPM) Be 17. Father's Name (First, Middle, Last)
Alfonso Matthews 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o 2 permit, Page 1 and 2 should be Geneva Burrell and l 19a. Informant's Name/Relationship (Type, Print) Gail Craig/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 8003 Lakecrest Dr. #201 Greenbelt, 20770 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Harmony Cemetery 10-12-12 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pridgen Funeral Service, PA 21. Signature of Funeral Service Licens Mulwara 20706 9013 Annapolis Rd. Lanham, MD 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE disease or condition Medical resulting in death) **Examiner** STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events OFOUND DEBILIT Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atter should be detached for Month Pregnant at time of death Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 💢 No Other: ည 1 ☐ Inpatient 2 🙀 ER/Outpatient 3 ☐ DOA this (5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) INO D71264 Jzw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Van Dusen Rd#220 Lawel, MD 20707 7350 Unegbu 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #23a Per FH JM 10 Ceztificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alma S. Pendleton October 2 11:00 a. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Magnolia Center Lanham 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 579-18-9959 **Director** 1 □ M 2 🗓 F 95 May 23, 1917 Spring Bank, VA Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA Prince William Woodbridge 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 4707 Lehigh Court 22193 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates Specify: Black 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supply Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jeremiah Stokes Julia Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parthenia W. Carter/ Niece 4707 Lehigh Court, Woodbridge, VA 22193 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Donation 5 Other (Specify) October 8, 2012 Suitland, MD 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Puneral Service Ticense 4111 Pennsylvania Avenue, Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death eneguence Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the at d be detached for g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 24a. Was an . Were autopsy findings available prior to completion of cause of page 2 autonsy death? After this certificate ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: No Other: မ 1 Inpatient 2 Impatient 3 Inpatient 3 Inpa 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury a 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical paraminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to only one) the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of ceriffier

31. Date filed (Month, Day, Year)

want it to all

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Lanham

A Property

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 20b per fh g933 11-29-12 vt
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death	Reg. N	0010	34983
and the same	Physic /Medi	cal	Edward 4a. Facility Name (If not institution, give street	Porch		(Oct. 6,	2012	3. Time of Death 7:55 A M
	Exami	ner	1790 Sollers What Social Security Number 6. Sex	f Road 7. Age (In yrs. last	Lusb	-		Calvert	lace (State or Foreign
	Funeral Director		217-36-6629 1 TAM 2		Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea June 23,	1939 K	try)
	Maryland a-f show	tor	10a. State 10b. County MD Calvert	2.	Town or Location			10	0d. Inside City Limits 1 □Yes 2 No
	h with the 23a or 28a	al Director	10e. Street and Number 1790 Sollers Whan		10f. Zip Code 2065	7		Citizen of What Count	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a fixedical Evertina in at be not liked at once.	by Funeral	1 Never Married 2 Married	as Decedent Ever in U.S. med Forces?	13. Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2 🟋 No		cify Yes or No- lican, etc.)	14. Race - America Black, White, e	etc.
Baltimore, Maryland 21215-0036	d within 72 ho giene. er than "natui ber edicel	Completed by	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) bllege (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Techni	during most of working d)	Re	Kind of Business/Ind staurant uipment	
land	uld be filee Mental Hy rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) $Ed\mathbf{ward}$		ch, Sr.	18. Mother's Name	(First, Middle, Malde Be11	en Surname) Johns	
, Mar)	and 2 sho saith and t 27 is ma er trauma	ľ	19a. Informant's Name/Relationship (Type. Pr Barry D. Porch/son	int)	19b. Mailing Address <i>(Street</i> 1790 Sollers	and Number or Rural S Wharf R	Route Number, City	or Town, State, Zip Box 105	Code) Tusby, MD20657
timore	t. Pages 1 attent of He trant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov. 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place	e of Disposition (Name of etery, crematory or other place Lt. Vets. Ce	<i>2</i> 5° em. 10∕ 17	tte 20c. -/2012 C	Location - City or Tov	wn, State .m., MD
Ba	permi Depar Impor any ir		21. Signature of Funeral Service Licensee	vell				eral Hom nce Fred	e, P.A. .,MD20678
2	Physician pe executed as the burial-transit as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated events	se on each line.	ce of):	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	ath ce attendir or use	Physician/Medical	in the past 12 months?	res, outcome of pregnancy Live birth 2 Fetal de Pregnant at time of deat	ath 3 Ectopic pregnanc	у		23d. Date of delive Month	ry Day Year
rds, P.	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions contributi	ng to death but not resulting	g in the underlying cause giv	en in Part I.		use contribute to th	,
ital Record	sician: The law requir certificate has been s rector, page 2 should t	Be Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 2	prior to con death?	osy findings available npletion of cause of 2 □ No
Division of Vital	ng Phys fter this meral di	Certification: To E	1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day, Year)	b. Time of lnjury M 1	er: 4 Nursing Hom y at \(\)? Yes 2 \(\) No	e 5 Residence		
<u>N</u>	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 ☐ Homicide determined 256 29a. Certifier 1 € Certifying Physician:	To the best of my knowled	, farm, street, factory, office	me date and place as	City or Town, Sta	(s) and manner as st	tated
	To the Ho within 24 h To the Full completely	Medical	/2 Medical Examiner: O	n the basis of examination d manner stated.	and/or investigation, in my o	ppinion, death occurred	d at the time, date a	and mainler as so and place, and due to Date signed (Month, L	the cause(s)
R.	64/1		30. Name and address of person who complete	od cause of death (Item CC	(a) (Type Print)	7324		Ī	12-
3	Sta	Ì	31. Date filed (Month, Day, Year)	32. Registra s Signature	Merrimac	CH, Prini	e Fred,	MI	
	Registr			112 Burn	B. back	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 per MD FCHD TM 10/24/12 State of Maryland / Department of Health and Mental Hygiene 34984 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Winifred G. Palmer $^{3.\,\text{Time of Death}}$ $7:45\ P_{M}$ Physician/ October 9 20 102 Winifred Isabelle Palmer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 094-32-5269 1 🗆 M 2 🖾 F 71 04/15/1941 NY Usual Residence of Deced 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 21K No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 6184 Viewsite Dr. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ٥ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) toxicologist medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Phillip Goldstein Fan Movchine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau John Wise/husband 6184 Viewsite Dr., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 10/11/12 Frederick, MD 21. Signature of Funefal Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, shock, or heart failure. Ust complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ a disease or condition resulting in death) 100 Medical Due to (or as a consequence of): Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) Examine Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 🛛 No 9 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 118810 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ral 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20a per fh. 932 10-31-12 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ 2-61 Parsons 1640 WESTER2 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MRROU Umra VURROII 1tospitul Westmister, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) Country **Director** 1 M 2 □ F 45 29 04 28a-f show 10a. State 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MO WEST MINGREZ VURROIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 WEILER 21158 1154 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?
Yes 2 \(\text{No } 1943-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify. 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Cap relephone should be filed with and Mental Hygien 7 is marked other th ble splicer Supervisor permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) မ Sessie *tarsons* eed 19a, Informant's Name/Relationship (Type, Prir Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number Parsons West monstor, MD Virginia 1000 weller 20a. Metbod of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 10/12/2012 4 ☐ Donation 5 ☐ Other (Specify) Hampstead 21. Signature of Funeral Service Lic 22. Name and Address of Facility uneral 412 Washication Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1 Onset and Death Immediate Cause (Final Physician/ TRACOT Cardioa disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner colon aunci Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury hyportenacy nio the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): g physician a as the burial Physician/Medical hlo aremier Chronio Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 3 for 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed del 23e. Did tobacco use contribute to the cause of death? þ theombaytopenia Chroni 1 Yes 2 10 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? SYNUOPE 24a, Was an autopsy performed/ Yes 2 X cate has I; page 2 s denudration this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury မ 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Countrying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one title of certifier Signature a 29c. License number 29d. Date signed (Month. Day, Year) Desing D. B. Keily, W. 062362

State Registrar 30. Name and address of person who

Memorial

Westmister,

2110 8

CU

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of Marylan				ental Hyg	giene	12	34986
		State Registrar		Cer	tificate of Dea	th		Reg. No. C	116	34700
Physicia	in/	Decedent's Name (First, Middle, La	<i>)</i>				2. Date of Dea	th Day	Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, giv-	e street and number)		4b. City, Town, or Loca	ation of Death	10	4c County	of Death	05:00AM
LXamiii		7201 24th. Ave.	,		Linderic	le lu	\supset	Prince	/	con Truck
Funeral		5. Social Security Number 6. S		ast birthday)	If Under 1 Year If U Months Days Ho	Inder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	n , Year)		(State or Foreign
Director		213-53-7953 Usual Residence of Decedent	1 ^X M 2 □ F 94	Yrs.			09/20/	1918	E1	Salvador
and show i at	0	10a. State 10b. County	10c. City	y, Town or Loc	cation				1	Od. Inside City Limits
Maryl 28a-f otifiec	irec	Md Princ	e George's Hy	vattsv:	ille					1 🕅 Yes 2 □ No
h the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
th wit ms 23 must	iner	7201 24th. Ave.	Tan Was Base 1, 45	. Ida u	20783	0::0/0	Y Was a Na	El Sal		
or dea	by Fu	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 [X] No		Vas Decedent of Hispani Yes, specify Cuban, Me	exican, Puerto F	Rican, etc.)		ce - America ck, White, e	
rsafte rral", Exan	ed b	3 → Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	Yes 2 No Spe	ecify:		Specify	Hist	anic
2 hour	plet	15. Decedent's E (Specify only highest gi		16a. Deced	ent's Usual Occupation and of work done during	most of workir	ta l	16b. Kind of B		
thin 73 ane. than ne Me	Completed	Elementary (Secondary (0-12)	College (1-4 or 5+)	life. Do	NOT use retired) Employed		9	Agric	cultur	e
ed wi Hygie other ent, tl	Be (17. Father's Name (First, Middle, Last)				Mother's Name	(First, Middle, I	Maiden Surnam		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportment of Health and Mental Hygiene and injury or other traumatic event, the Medical Examiner must be notified at once.	10	Unknown					a Roman		,	
should and N is ma auma		19a. Informant's Name/Relationship (1	g Address (Street and N					ode)
and 2 lealth sm 27 her tr		Oscar Salomon			24th. Ave	1				
int of H		20a. Method of Disposition 1 Disposition 2 Cremation 3	Removal from State	emetery, cren	sition (Name of natory or other place)		ate	20c. Location		
nit. Pa artmel ortani injury		4 Donation 5 Other (Spec	ify) Ge		Cemetery Name and Address of F	10/2			alvado	
Dep Imp		Chilens m	T. BUI		005 12th. St					
		23a Part 1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the death							Approximate
hysician/		Immediate Cause (Final disease or condition	Pulei	Lia					4	Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):						
	er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequ	ence of:						
ansit and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0) 40 40 00 100 40							
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ate be ohysic the bu	dical	•	d							
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eath c atter d for u	icial	in the past 12 months?	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)					Day Year
the d by the tache	Physician/Me	g 🗌 Unknown	g ☐ Unknown							
requires that the death certificate is been signed by the attending physishould be detached for use as the	ρ	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause given in	Part I.				e cause of death?
requir	etec	HOUGESTIVE	Thattan	er –						<u> </u>
e law l e has t ge 2 s	Completed	Anemia					24a. Was a autop perfor	sv	prior to cor death?	sy findings available npletion of cause of
an: Ih lificate tor, pa	Be Co	25. Was case referred to medical			26. Place of	f Death (Check	perfor	2 🔼 No	1 Yes	2 ∐ No
ysicia is cert direct	To B	examiner?	Hospital:	ER/Outpatien	_ Other	,	-	ence 6 🗆 Oth	er (Specify)	
ng Ph fter th uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	2	8d. Describe ho	ow injury occur	red	
ttend death tor: A y the f	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not t	be 290 Place of laium. At ho	mo farm etro	M 1 Yes		005 1 ti (C		an on Ownel	Douts Number
after Direc d in by		4 Homicide determined	building, etc. (Specify)		et, factory, office		City or Town	treet and Numb n, State)	er or Hurai	Houte Number,
ospita hours uneral	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination	edge, death o	ccurred at the time, date	e and place, an	d due to the ca	use(s) and man	ner as state	d.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours afrect add. To the Funeral afrector: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Me	only one) 3 Certifying Nur	rse Practitioner: To the best of m		death occurred at the tim	ne, date and place	e, and due to the	ie cause(s) and i	manner as s	tated.
2 4 5 5		29b. Signature and title ficertifier	1)		29c. License numi	61:	241	29d. Date signe	= 17	yay, rear)
		30. Name and address of person who	completed cause of death (Item	23a) (Type, P		- 1 -	- ()	1011-	ب امعاد	
		ARVIND SOT 7	05 Digital Dr;	Se.G	linhice	in, l	Dalo	70		
Stat Registra		31. Date filed (Month, Day, Year) OCT 1 6 201	2 Registrar's Signat	par par	Get.	,				

Registrar DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JOHN FREDERICK REXFORD 2012 1:20 A M Medical 4a. Facility Name (if not institution, give street and number) WALTER REED 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL MILITARY MEDICAL CENTER MONTGOMERY BETHESDA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Months Hours (Month, Day, Year, 179-32-6612 72 Director 1 ፟M 2 □ F 6,1940 Pennsylvania Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Directo VA Fairfax Springfield 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8805 Aquary Ct. 22153 USA within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1962 Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Caucasian Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. United States Elementary/Secondary (0-12) College (1-4 or 5+) 5 + Intelligence Officer Air Force traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ٥ Jesse Rexford Pearl Westerling Rexford and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health airtem 27 i Susan Marie Rexford/Spouse 8805 Aquary Ct., Springfield, VA 22153 Department of Health Important: If item 27 any Injury or other tronge. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery crematory or other place)
Arlington National unknown
Cemetery 1 X Burial 2 Cremation 3 Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition STAGE IV SQUAMOUS CELL CARCINOMA Medical resulting in death) Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): RESPIRATORY DISTRESS resulting in death) Last attending physician a I for use as the burial-Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day the detached 9 Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed cate has been signification cannot be care as seen significant care as 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 No After this certificate 1 Yes 2 No Physiclan: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ည 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th Completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 010105 811

State Registrar BETHESDA, MD 20889

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY

2. Registrar's Signature

WANKO

31. Date filed (Month, Day, Year)

OCT 16 2012

MEDICAL

				Please	Type or Pr						•	•	•	
			For State		State of M	laryland				and Menta	Hygien	e	0 01	000
		-	Registrar 1. Decedent's Name	e (First, Middle, La:	st)		Ce	rtificate of	Deatn		Reg. I	lo U	3. Time of	707
П	Physicia Medi		Pedro	Franco	Rivera					Mon	th [b 2013		
30-16	Exami		4a. Facility Name (if Dorche		estreet and number)	Hosp	ital	4b. City, Town, o		of Death		c. County of Dea		
	Funeral Director		5. Social Security N 582-50-	umber 6. S		ge (In yrs. las	t birthday)	If Under 1 Year Months Days			of Birth th, Day, Year		rthplace (State of State)	0
	/land f show ed at	tor	Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	ocation	Live	clock			10d. Inside Ci	
	the Man or 28a- oe notifie	Funeral Director	MD 10e. Street and Nun		<u> </u>			10f. Zip Code			10g. (Citizen of What C		2X No
	tth with ms 23 must b	nera		ler Road	12. Was Decedent	From in 11.0	Lan		21643			ited Sta		
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Marri 3 🂢 Widowed	ied 2 Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			If Yes, specify Cub	an, Mexica	rigin? (Specify Yes of an, Puerto Rican, etc y: Puerto I	o.)	14. Race - Ame Black, Whi Specify: Pt		can
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	within giene. ner tha	0	Elementary/Seco		College (1-4 or	5+)		culture 1		ician	F	erdue/Po	oultry	
Maryland	uld be filed Mental Hy narked ott	To Be	17. Father's Name (A	First, Middle, Last) S Franco					1	her's Name <i>(First, M</i>	iddle, Maide. ivera	n Surname)		
	e 1 and 2 shou of Health and If item 27 is n or other traum			Franco/I			700	6 Butler		per or Rural Route N Hurlock			p Code)	
Baltimore,	9 5 ± 5		20a. Method of Disp 1 Durial 2 Donation		Removal from State	cer	netery, crer	osition (Name of matory or other pla metery	ce)	Date 10/23/12	1 _	nce, Pue		a
Ball	permit. Page Department Important: any Injury o		21. Signature of Fur	neral Service Licens	W. Coale	2		2. Name and Addre		ity Frampt t., Feder	om Fur alsbur	eral Ho	me, P.A. 1632	•
	Physician		shock, or hear Immediate Cause (I disease or conditio	t failure. List only o Final	plications that caused ne cause on each line	d the death. e. er Sh	1 -	er the mode of dyir Kenul Ce	ng, such as	s cardiac or respirat	ory arrest,		Approximate Interval Bety Onset and D	veen
-	Medical Examiner		resulting in death)		Due to (or as	a consequer		1 1 1	talia,	rant lun	1 noc	lular		
	ted nsit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying injury	Due to (or as	a consequer	nce of):		100	to rathy	7.00	(V.W)	,	
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376(ficate g physas the	Medi			a									
. Box 68760	The law requires that the death certificate be after has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 0 9 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3	Ectopic pregnand Other (specify)	су			23d. Date of de Month	,	ear
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Division of Vital Records,	s ician: The law rec certificate has bee lirector, page 2 sho	Completed		- Con	onary a	rtery	_di	feero.			Was an autopsy performed?	prior to	topsy findings a completion of ca s 2 \(\sime\) No	
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ν of V	Phy this ald	ate: To	27. Manner of Death	5 Pending	28a. Date of inju (Month, Day	ry 28	R/Outpatier Bb. Time of injury	28c. Injur	4 □ N y at </th <th>_</th> <th>Residence ribe how inju</th> <th></th> <th>sify)</th> <th></th>	_	Residence ribe how inju		sify)	
ivision	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined			e, farm, stre	M 1 L	Yes 2	28f. Locat	ion (Street a or Town, Stat	nd Number or Ru e)	ral Route Numbe	ər,
	e Hospita 24 hours e Funeral bleted filled	Medical	(Check 2	Medical Exami	sician: To the best of ner: On the basis of e se Practioner: To the	xamination a	nd/or invest	igation, in my opinio	on, death c	occurred at the time.	date and plac	e, and due to the	cause(s) and mar	ner stated.
	To the vithing the complete of		29b. Signature and t		(abib)	4D		29c. Licenso		28		ate signed (Mont		
	Ti di di di di di di di di di di di di di		30. Name and addre	ss of person who c	ompleted cause of d	eath (Item 23	3a) (Type, P	(rint) Car	nbriz	elan MD	216	13 -		
	Stat Registra	~	31. Date filed (Month	Day, Year)	32. Registra	ar's Signatur		/		<i>O</i>				
						1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Oct. 13^{Day} Bertha Jeanette Russell 2012 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4349 Russell Road Hurlock Dorchester 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 221-20-5593 Director 1 □ M 2 🗓 F 76 Delaware May 3, 1936 ir then "netural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Hurlock 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4349 Russell Road 21643 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. \$ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 to the set he ath and Mentel Hygiene.
If item 27 is merked other then "nother traumatic event, the Median Elementary/Secondary (0-12) College (1-4 or 5+) 11 grad. Beautician Beauty Salon e 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Ellis Ford Bulah Thelma Elizabeth Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Briggs/Daughter 10 MacDuff Ct. Newark, DE 19711 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) MD Veterans Cem. 110/22/12 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility bSlove CPSP Framptom Funeral Home, Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sicien end buriel-trensit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physicien the doring the burie Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director, After this certificate hes been signe completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No 25. Was case reference in medical æ 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cay se of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Lindsay Young

31. Date filed (Month, Day, Year)

Federalsburg,

MD 21632

215 Bloomingdale Ave

32. Registrar's Signature

			Please	Type or F						-		_	e.	
		-	For State	State of	Marylan		artment of tificate of		and iv	ientai Hy	•	001	0 0	1001
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Cei	uncate or	Deatii	-	2. Date of De	Reg. No	o. <u>/</u> U	4 3	ime of Death
	Physicia Medic		Charles W. Reese	, Jr.						Month Octobe	Da		ar	12:43PM
1	Z Examin		4a. Facility Name (if not institution, give		-		4b. City, Town	or Location	of Death	OCLOBE		c. County of D		12.40111
	<i>i</i>		1320 East Centra				Mayo				A	nne Ar	undel	
	Funeral Director		5. Social Security Number 6. S	Sex 7.	. Age (In yrs. la	ast birthday)	If Under 1 Year Months Day		Min.	8. Date of Bir (Month, Da		9.	Birthplace (S Country)	State or Foreign
			213-30-1478 Usual Residence of Decedent	MAN 2 LIF	7	7 Yrs.				January	2,19	35 Ma:	ryland	
	/land f sho	tor	10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Ins	side City Limits
	Mary 28a-	irec	Maryland Anne Ar	rundel	May	о							1	Yes 2 X No
	ith the	ral	10e. Street and Number				10f. Zip Code				10g. C	itizen of What	Country?	
	hours after death with the Maryland neturel", or Items 23e or 28a-f sho heel Examiner roust to bothled at	by Funeral Director	1320 East Central	Avenue 12. Was Decede	ent Ever in U.S	S 113.V	21106 Was Decedent of	Hispanic O	rigin? (Spe	cify Yes or No-		14. Race - A	JSA mariaan ladi	inn
9	or Its	by F	1 Never Married 2 Married	Armed Force	es?	1	f Yes, specify Cu	ban, Mexica	an, Puerto	Rican, etc.)		Black, W		di;
21215-0036	urel",	ted	3 🗓 Widowed 4 🗌 Divorced	If Vac Give	s. 1955–	58	I∐Yes 2⊠I	No Specif	y:			Specify:	White	
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<u> a</u>	ld be f Menta erked etic ev	욘	Charles W. Reese.	Sr.				Carr	ie Dr	o11				
Maryland	shout and I is m		19a. Informant's Name/Relationship (7			19b. Mailir	ng Address (Stre	et and Numl	ber or Rura	l Route Numbe	er, City o	r Town, State,	Zip Code)	
	and 2 s Health em 27 her tr		Barbara Reese Jewe	eler/Dau			Monmouth	Ave.			_			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28a-f show eny Injury or other treumetic event, I've Medical Examitter must be invitiled at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		tate c	emetery, cren	sition (Name of natory or other p			Date		_ocation - City		
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			23a. Part 1 Enter the disease, or com	plications that cau	used the deat							ewater,	Appro	oximate
E-<	Physician/		imock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each	1 1-	lyoca	dial	Trafe	cat				♠ Onse	al Between t and Death
€	Medical		resulting in death)	a. Due to (or	as a consequ	_	0(141	Diffe	M L I					lou(
	Examiner	<u>.</u>	Sequentially list conditions,	bO[abete		ika						34	ears
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9 ×	h cert tendir or use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregna	ncy al death 3 [Ectopic pregna	ancy			1	23d. Date of		
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o	ling P.	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	injury Day, Year)	28b. Time of injury	w	ork?		28d. Describe	how inju	ry occurred		
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Division of Vital Records,	of or A	S	4 LJ Homicide determined	building	, etc. (Specify)	set, factory, offic	e		28f. Location (City or To			Hurai Houte	ivumper,
	To the Hospitel or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use es the light	Medical	29a. Certifier 1 Certifying Phy	rsician: To the bes	t of my knowl	ledge, death	occurred at the t	ime, date an	nd place, ar	nd due to the c	ause(s)	and manner a	s stated.	5.0-2-4
	the Hi nin 24 the Fu	Mec	(Check 2 Medical Examonly one) 3 Certifying Nur	iner: On the basis se Practitioner: T	of examination the best of n	n and/or inves ny knowledge	tigation, in my op , death occurred	inion, death at the time, o	occurred at late and pla	the time, date ice, and due to	and plac the caus	e, and due to t e(s) and mann	he cause(s) a er as stated.	ind manner stated
-	Vitt To 1		29b. Signature and title of certifier	2-7	L.			nse number			-	ate signed (Mo		•
			Mamil	Jus	-,m			3856	02		Uć.	tober 1	0,20	012
-	HILL		30. Name and address of person who	completed cause	of death (Item				1/0	20	hla	st R	iver	mo
	Sta	e	31. Date filed (Month, Day, Year)		istrar's Signar	ture	34 ON	NO IV	NUL (1	100	01 11	10-1	1.12
	Registr		OCT 1120	112 Con	me ,	1. 10	ale							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Juanita Reitan October 2012 3:09 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 177-28-9197 Director 79 1 □ M 2 🔀 F Yrs July 28, 1933 Pennsylvania Usual Residence of Deced 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Maryland Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1179 Hampton Road 21409 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ٥ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black Completed 3 KWVidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Artist Art other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o William Howard Hall Ethel Dandridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is eny Injury or other trauonce. Janice Marie Turner/daughter 1179 Hampton Road Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/15/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Juneral Service 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cevelial 10.5 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use es the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
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1 ☐ Yes 2 ☐ No 24a. Was an performed' 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 H0 Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in musclim Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License numbe

Registrar
DHMH 17 Rev 06-2011

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State

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2012 **Physician** 9:30 pM William Robert Ryan 10 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Allegany Frostburg 10023 Engletown Rd SW If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Maryland 79 Director 220-30-8375 Usual Residence of Decedent the Maryland 10d. Inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 No **Funeral Director** MD Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with itent of Health and Mental Hygiene.
ant: If time Z7 is marked other than "natural", or items 23a or items up or other traumatic event, Ite Moulcal Examiner must be runy or other traumatic event, Ite Moulcal Examiner must be. U.S.A. 21532 10023 Engletown Rd SW 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1953 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: white Specify و ک 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ABL Cafeteria Janitor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ryan Robert Ryan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10023 Engletown Rd SW Frostburg, MD 21532 Mary Lou Ryan 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of It Important: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-18-2012 Eckhart Cemetery Eckhart, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sowers Funeral Home, P.A. 21. Signature of Funeral Service Licensee Man MO0547 60 W. Main Street Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mart to Carcinoma month **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached f □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes — 2 ☐ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 / Natural 1 ☐ Yes 2 ☐ No after death Director: A 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) 0CT 3 1 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospitel or Attending Pt within 24 hours after death.
To the Funerel Director: After th completely filled in by the funerel

DHMH 17 Rev 06-2011

Registrar

State

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

OCT

12

ORIGINAL

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Day

3. Time of Death

2230

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 🗆 Yes 2 🏝 No

Korea

Asian

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

> 29c. License number 29d, Date signed (Month, Day, Year)

2012

D 700 427

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis treisinger MD

Francis Freisinger MD

1500 Forest Glen Dr. Silver Spring, Md 20910 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, #5, per fb, g934 12-12-12 sm State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 31, 99 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ oct. 5.2012 1604 M Fern Rae Simmons . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Takoma Park Montgomery 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, . 1 9 4 0 1 M 2 S Months Days Hours 303-4 Indiana Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location death with the Maryland 10d. Inside City Limits Director Louisville KY Jefferson 1X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Apt.4 40291 5301 Hames Trace USA Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married permit. Page 1 and 2 should e filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is man ed other than "natural", or any injury or other traumati event, the Medical Examin þ Yes 2 W No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Iva Lee Earl Ray Waggoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40291John E.Simmons/Husband 5301 Hames Trace Apt.4 Louisville, Kentucky 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Hickory Grove Cem: 10/13/2012 Borden, Indiana 21. Signal dr. vol. Funeral Service TTTT TO TO REFERENCE, P.A. <u>9241 Columbia Blvd.Silver Spring,Md20910</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ARTERIOSELEROTIC CARDIOVASCULA disease or condition 45-485 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any course of the Underlying Cause (Disease or iinjury that initiated events Examine Drin to for ea a nonacquence off g physician and as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 1 Yes 2 No 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by amore Encephalopathy/Respiratoy Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Vent lator Dependent 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy End Stage Ronal Disease / Hemidiale, 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🗷 No ပ 1 Inpatient 2 AER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural Accident 5 Pending 1 Tes 2 No Investigation Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 📂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Paulank

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Ectober 6 2012

Hyattswille MD 2018

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) U 2. Date of Death Physician/ Month Spitzer p^{M} Murray 2012 October 5:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Assisted Living Silver Spring Montgomery Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min. 262-26-4962 89 Director 1 DKM 2 D F Aug. 2, 1923 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location rector 10d. Inside City Limits Montgomery Silver Spring 1 Yes 2x No ö 10e. Street and Number 10g. Citizen of What Country? Funera 3701 International Drive, Apt. 115 20906 IISA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 H No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) US Dept. of Education 5+ Mathematician permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last)
Henry Spitzer 18. Mother's Name (First, Middle, Maiden Surname) Rose Narvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana McClintock/Power of Attorney 2363 Heather Drive, Decatur, GA 30033 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State October 13 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee Panagered Address Coffilians Funeral Home Inc. No 500 University Blvd., W., Silver Spring, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ a Advanced Esophageal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): e burial transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year ed by the a Yes 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ å been signated Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4¾☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🖾 No Hospital or Attending Physician: The law has page 2 After this certificate 8 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Living
6 Other (Specify) Other: 4 Nursing Home 5 Residence 2 🖾 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending thin 24 hours after death.

the Funeral Director; Aft
empletely filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

15

To the I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sunitha Bhogavilli, MD 9801 Georgia Avenue, Silver Spring, MD 20902

3. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D54566

29d. Date signed (Month, Day, Year)

October 12, 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death IVAN Month **Physician** /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 5. Social Security Number If Under 24 Hrs. If Under 1 Year 6. Sex Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Funeral Hours 1MM 2NF Months Days 215-01-1002 Yrs. Director Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Locetion 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 0 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? e filed within 72 hours efter on Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 Note of Yes, Give Yeer or Dates: 2 No 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ABINET 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be in Depertment of Health and Mentel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SBURG MD21632 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other plece) 6 1 Buriel 2 □ Cremation 3 □ Removal from State FEDERALSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WERAL HOME WILLIAMS ON FUNERAL HOME 311 S. MAINST. FEDERALSPURG, MD 21632 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ear Examiner to (or as e consequence of) Examiner The law raquires that the death certificeta be axecuted buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as e consequence of) attanding ph Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably complately filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? certificate hes 200 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) 20 NO edicai Certification: To 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 28c. Injury at Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2012 30 Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

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6 2012

31. Date filed (Month, Day, Year)

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32. Registrer's Signature

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Easton, mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 30 per DVR G933 11/5/12 dk.
State of Maryland / Department of Health and Mental Hydiene

				State of Maryland				Mental Hy	giene			
			State Registrar		Cer	tificate of L	Death		Reg. No. 2	12,34998		
	Physicia		Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death		
A Part	Medic Examin		Claser Mary Searc 4a. Facility Name (if not institution, give stree	et and number)		4b. City, Town, or	Location of Dea		10/08/2012			
1			Washington Adventis	+ Hospital		Takoma			Montg			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1 Year Months Days			th	Birthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent	_{1 2} ¥ _F 65	Yrs.	, ,		11/23/		North Carolina		
	and show	ro	10a. State 10b. County	10c. City	, Town or Lo	cation		1 / /		10d. Inside City Limits		
	Maryl 28a-f otifie	Director	Maryland Prince Geo:	rges Hya	ttsvil	le				1 XYes 2 ☐ No		
	th the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?		
	ms 2	Funeral	6030 Sargent Rd.	Was Decedent Ever in U.S.	110.11	20782	i O-i-i-0 (6	S	USA			
9800	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by Fi	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	H	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 【XNo	n, Mexican, Puei	to Rican, etc.)	Black	e - American Indian, k, White, etc. Black		
21215-0036	hin 72 hou ne. than "nat te Medica	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give k	lent's Usual Occupa kind of work done of ONOT use retired)		orking	16b. Kind of Bus	·		
d 2.	ed with Hygien other i	Be C	17. Father's Name (First, Middle, Last)		Seam	stress	10 Mathaula Ma		Manufac			
/lan	should be filed to and Mental Hyg 7 is marked other raumatic event,	70	James Moore					me (First, Middle, Bell Rob	Maiden Surname) eson			
Maryland	of and 2 should be of Health and Ment fitem 27 is marked rother traumatic errother traumatic		19a. Informant's Name/Relationship (Type, Information of the Informati			g Address (Street a				ate, Zip Code)		
e,	ge 1 and it of Heal if item 2		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of natory or other place		Date		City or Town, State		
Baltimore,	t. Page tment tant: I		1 Durial 2 T Cremation 3 Rem		sapeak	e Cremato	ory 10/			le, Maryland		
Bal	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licenses	Senden		Name and Addres						
			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one callmmediate Cause (Final	use on each line.			g, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death		
gur i	hysician/ Medical		disease or condition resulting in death)	respirato; Due to (or as a conseque		ailure		_		Shoot and Dodin		
nist day.	Examiner	-e	Sequentially list conditions b	Hodgkins		homa						
	nted d ansit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):							
	ate be executed ohysician and the burial-transit	EX	that initiated events c. = resulting in death) Last	Due to (or as a conseque	ence of):							
	ate be ohysic the bu	dice	d									
687	eath certifica attending ph for use as t	/M	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnan	cy				001 5.4	of delices		
Вох	ė e ė	Physician/Me	in the past 12 months?	1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	У		Mon'	e of delivery th Day Year		
ls, P.O.	uires that n signed I uld be det	Completed by F	Part II. Other significant conditions contrib	uting to death but not resul	Iting in the ur	nderlying cause giv	en in Part I.			bute to the cause of death? 3 Probably 4 Unknown		
cor	law require has been si ge 2 should	nplet						24a. Was	osy pr	ere autopsy findings available rior to completion of cause of		
Ä	ician: The la certificate ha rector, page		OF Man consentenced to condition					1 Yes		eath?		
/ita	ysician: is certific director,	m	25. Was case referred to medical examiper? 1 ☑ Yes 2 ☐ No Hosp	ital:	,	Othe	r: Death (Che					
on of \	nding Phys ith. After this e funeral di	cate: To		1 ☐ Inpatient 2 ☑ E 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		lence 6 Other	```		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. On the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	I Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre			28f. Location (S City or Tow		or Rural Route Number,		
	he Hospita in 24 hours he Funeral npletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 0 Gentlement of the Check only one) 3 Certifying Nurse Pro	To the best of my knowled On the basis of examination a actitioner: To the best of my	and/or investi	gation, in my opinio	 n, death occurred 	at the time, date a	nd place, and due t	to the cause(s) and manner stated.		
	To the New Within 24 To the Recomplete		29b. Signature and title of certifier	01-		29c. License	number		29d. Date signed			
	25M	1	30. Name and address of person who compl	eted cause of death (Item 2	23a) (Type, Pr		1		1-12	7 - ~~		
			Anna Beth Ansaldo,				200, Ger	mantown	MD 20874	+		
	Stat Registra	e ır	31. Date filed (Month, Pay, Year)	32. Registrar's Signatur	bark	2						

DHMH 17 Rev 06-2011

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012^{Yea} 9 8:38 Gilmer Hench Smith \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1142 Rosemont Drive Knoxville Frederick Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 230-52-8528 **Director** 1 💢 M 2 🗆 F 74 5/20/1938 Maryland or 28a-f show e notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 😾 No Frederick Knoxville 10e. Street and Number ò 10f. Zip Code ritems 23a or ner must be r 10g. Citizen of What Country? Funeral 1142 Rosemont Drive 21758 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian other traumatic event, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No "natural", 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 th and Mental Hygiene.
27 is marked other than " (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Project Manager Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gilmer Donald Smith Cecile Mae Bloyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Cheryl Reynold, Daughter 1142 Rosemont Drive, Knoxville MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

✓ Burial 2

✓ Cremation 3

✓ Removal from State Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2012 Lovettsville VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20 John T Williams Funeral Home, Brunswick MD 21716 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Due to (ar as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav 5 Other (specify) 9 Unknown det Part II. **Other significant conditio**ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ္ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accident Investigation within 24 hours after deat

To the Funeral Director:
completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, Year) State 32 aistrar's Signature Registrar